PHARMACEUTICAL PRICES, AND DRAFT LEGISLATION ON HOMELESS VETERANS' PROGRAMS AND ISSUES RELATED TO PERSIAN GULF WAR ILLNESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

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THURSDAY, JULY 10, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Moran, Cooksey, Hutchinson, Gutierrez, Evans, Kennedy, and Peterson.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Subcommittee on Health will be in order. We'll start with my opening statement.

This morning's hearings provide us an opportunity to review aspects of some of VA's most important programs. One is important because of its sheer size. It is VA's Pharmacy Program. Viewed simply as a procurement effort, VA buys and dispenses more than $1 billion in pharmaceuticals. VA's entire medical care budget is some $17 billion, to put it in perspective.

The second area is important because of the sheer size of the problem it attempts to tackle. I'm referring now to VA's efforts to assist homeless veterans. The statistics are quite remarkable. Data suggests that one third of all homeless adults are veterans.

We face legislative questions in both of these areas. Studies indicate that substantial numbers of those who rely on VA care are homeless or at risk of becoming homeless.

VA has developed many specialized programs to assist homeless veterans. Significantly, several of these programs are based on statutory provisions that expire this year.

Congress has not to my knowledge examined these programs comprehensively in some time. We have that opportunity this morning. We will also consider draft legislation that would consolidate, clarify, and strengthen these programs.

In the pharmaceutical area, statutory provisions which have not yet been implemented as well as recent legislative proposals pose a risk of substantially raising VA drug prices.

Given the budget pressures the VA medical system already faces, a marked increase in drug prices could have far-reaching effects,

adverse effects, on veterans' care. We should examine this potential and consider whether there is a need for further legislation to help safeguard our veterans.

I look forward to the testimony of our witnesses and to working with Mr. Gutierrez and the members of the Subcommittee in addressing these complex issues. Now I turn to my colleague for his opening statement.

OPENING STATEMENT OF HON. LUIS GUTIERREZ

Mr. GUTIERREZ. Thank you very much, Mr. Chairman. Thank you for holding this important hearing today. We have a variety of critical issues to deal with today. And I want to make a few brief comments on each of the topics our witnesses will address and then allow the experts to speak for themselves.

I think the first one you have already heard, Mr. Chairman. Between 1990 and 1991, the Department of Veterans Affairs explained that Medicaid rebates caused an unanticipated $79 million pharmaceutical price increase for VA drug purchases.

On the review of the GAO testimony and the VA's analysis, I fear that this costly situation may occur again if State and local providers are allowed to make their purchases from federal supply schedule that VA negotiates with federal pharmaceutical providers.

I have recently been informed that legislation permitting federal providers to purchase pharmaceuticals off the supply schedule is being considered in Congress. Allow me to reiterate my basic contention.

Based on past experience, we know that VA drug manufacturers can and most likely will raise the prices for VA and other federal health programs. I'm deeply concerned about this.

The second issue that I want to address is the reauthorization of a number of other vital programs. I believe that the VA's comprehensive approach in treating homelessness, this highly vulnerable population, is something. More should be done.

And I just want to make echo of the fact that one-third of all the homeless males are veterans. Assisting these individuals who served our nation is not inexpensive. The answers to their problems are very complex. However, I don't know that you can place a dollar amount on the work that needs to be done for them and with them.

I am also pleased that we are going to receive testimony regarding the proposed legislation to implement a new grant program to establish treatment programs for Persian Gulf veterans. They have been suffering too long, and I hope that these programs see the light of day in their implementation so that we can guide the VA once again into this area of such importance.

Once again I want to thank Chairman Stearns for convening this important hearing. And I look forward to working with you to pass these critical bills we will examine today. Mr. Chairman I would also ask unanimous consent that the entirety of my opening statement be placed in the record.

Thank you so much, Mr. Chairman.

[The prepared statement of Congressman Gutierrez appears on p. 27.]

Mr. STEARNS. Thank you. Mr. Hutchinson.

OPENING STATEMENT OF HON. ASA HUTCHINSON

Mr. HUTCHINSON. Thank you, Mr. Chairman. I want to express my thanks also to you for conducting this hearing. These issues that the panelists will present today are very important.

In my District, I have a very large veterans' population. And the price of pharmaceuticals is a critical part of their daily life that they have to deal with. I am concerned about the effect or the possible effect of price increases that could be imposed on the pharmaceuticals purchased by veterans if access to the federal supply schedule is expanded. So this testimony is very important.

And also in regard to the homeless, it's amazing to me that we have such a large veteran population that still suffers from homelessness. Certainly the veterans' programs and the homeless programs that deal with the issue are very important, but I think it's appropriate to look at the possible consolidation and make sure that they're effective.

So I look forward to the testimony today. Mr. Chairman, I thank you.

Mr. STEARNS. I thank my colleague.

Mr. Peterson?

Mr. PETERSON. I don't have a statement, Mr. Chairman, but I want to thank you for calling this hearing and for your leadership on these issues.

Mr. STEARNS. Thank you. We'll have the first panel: the director of Health Services Quality and Public Health Issues from the GAO, Ms. Bernice Steinhardt; accompanied by: John C. Hansen, the Assistant Director of Health Services Quality and Public Health Issues, General Accounting Office. We also have John Ogden, Chief Consultant, Pharmacy Benefits Management Strategic Health Group, Department of Veterans Affairs.

Good morning to you. And let me welcome all of you. We're glad to hear your testimony this morning.

Ms. STEINHARDT. Thanks very much.

STATEMENT OF BERNICE STEINHARDT, DIRECTOR, HEALTH SERVICES QUALITY AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JOHN C. HANSEN, ASSISTANT DIRECTOR, HEALTH SERVICES QUALITY AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE; JOEL HAMILTON, ANALYST; AND JOHN OGDEN, CHIEF CONSULTANT, PHARMACY BENEFITS MANAGEMENT STRATEGIC HEALTH GROUP, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MEL NOEL, ESQ.

STATEMENT OF BERNICE STEINHARDT

Ms. STEINHARDT. Good morning, Mr. Chairman and members of the Subcommittee. We appreciate very much the chance to be here today. If I may, I'd like to just make a couple of introductions. John Hansen was the director in charge of our work. And Joel Hamilton, who is in the audience, was the principal analyst.

With your permission, I'd like to submit my full statement for the record and summarize my remarks here.

Mr. STEARNS. Without objection.

[The prepared statement of Ms. Steinhardt appears on p. 34.]

Ms. STEINHARDT. Thank you.

We would like to share with you this morning what we learned about how VA and other government purchasers might be affected if the federal supply schedule for pharmaceuticals were open to State and local governments.

The Federal Government, as you pointed out, is a large purchaser of pharmaceuticals. We spent almost $1.3 billion on drugs purchased from the schedule in 1996.

VA is by far the largest of these federal buyers, accounting for more than 70 percent, or over $900 million, of that total. About six percent of VA's discretionary budget went towards drug purchases last year and about seven and a half percent of its medical care budget. So any potential changes in federal drug prices can obviously have important consequences for the Department.

Before I turn to our findings, let me just provide some background here. You may recall that FASA, the Federal Acquisition Streamlining Act of 1994, authorized GSA to establish a cooperative purchasing program with State and local governments based on the assumption that combining purchasing power would benefit both the Federal as well as State and local governments. In essence, the program was intended to give State and local governments access to the same prices that vendors give to federal purchasers under negotiated supply schedules.

Last year in the Klinger-Cohen Act, the Congress suspended GSA's authority for this program and directed GAO to assess its potential effects on Federal agencies, State and local governments, and on industry.

Our colleagues in GAO have reported on the overall program, but the pharmaceutical industry is unique and the Federal Government is a big purchaser of drugs. Twenty percent, in fact, of all dollars spent on supply schedule purchases last year were for drugs. That's one-fifth of all supply schedule purchases. We in the health group, therefore, took a separate look at the effects of opening the pharmaceutical schedule to non-federal purchasers.

To sum up, we concluded that it isn't really possible to predict how federal drug prices would be affected if State and local governments were allowed to buy pharmaceuticals from the supply schedules since prices ultimately are determined by negotiations between VA, which acts as the Government's agent, and industry.

But the factors involved in negotiations, particularly the size of the market that would be created, has the potential to produce an upward pressure on prices. If prices were, in fact, to rise, VA and a few other federal purchasers would be somewhat protected by the Veterans Health Care Act, which sets a cap on prices for over a quarter of the drugs on the schedule.

VA believes, however, that it could still experience increases in costs for generic drugs which are not subject to the caps and for those drugs whose prices are now below the ceiling. Other Federal agencies would not be protected at all.

For State and local governments, there could be benefits but only to the extent that schedule prices were lower than what they could negotiate on their own. Let me just take each of these points in turn.

First, as I said, VA's negotiations with manufacturers will ultimately determine the prices on the schedule. Up to now, VA has been able to get substantial discounts from manufacturers, in part because the Veterans Health Care Act requires it and in part because manufacturers are willing to give good prices in return for access to VA hospitals, where many of the nation's physicians receive their training.

However, if manufacturers had to make these prices available to a larger market, they might be considerably less willing to continue to offer these prices. Currently the federal market accounted for by the FSS, the federal supply schedule, represents about one and a half percent of domestic pharmaceutical sales. Depending on how one were to define an eligible State or a local entity, though, this market could increase by at least 4.4 percent; that is, a threefold increase.

Public Hospital Coalition, speaking for State and local government purchasers, argues that the increase would be much smaller because of restrictions in State procurement laws. But even if the increase were just a half percent, as the coalition has argued it might be, this would still be a 33 percent increase in the size of the supply schedule market.

While we don't know what the actual size of the increase in the market might be, we do know from historical experience that having to offer discounted prices to a larger market puts an upward pressure on drug prices. After the Medicaid rebate program was enacted in 1990, manufacturers were required to give State Medicaid programs rebates for outpatient drugs on the basis of the lowest prices they charged other purchasers. In reaction, manufacturers substantially raised the prices they charged other purchasers.

If prices were to rise once the schedule was opened, the effects on different government purchasers would vary. For VA, DOD, the Public Health Service, and the Coast Guard, the four agencies covered under the Veterans Health Care Act, roughly one-quarter of the drugs on the supply schedule would still be subject to ceiling prices, which are currently set at about 75 percent of the average manufacturer's wholesale price.

For VA, the drugs that come under the price caps account for about three-quarters of the Department's drug costs, but the schedule prices of some of the drugs are currently below the ceiling price. So VA has estimated that its costs for these drugs could go up almost 30 percent, or close to $70 million, a year if prices were to rise to the ceiling.

For the non-protected drugs, which are mostly generics, VA estimates that it would have to pay almost $84 million a year more if it were paying wholesale, rather than schedule, prices. Altogether, then, VA believes that its costs could increase by over $153 million a year if schedule prices were to rise.

Federal purchasers other than those protected by the Veterans Health Care Act would pay full schedule prices on all drugs bought from the schedule. According to the Public Hospital Coalition, State and local governments would benefit from access to the schedule because the coalition assumes there would be little effect on prices.

They estimate that State and local government drug prices are now 17 percent higher on average than supply schedule prices. So

if schedule prices were to rise, they might still be lower than what State and local governments have been accustomed to paying. On the other hand, if the schedule prices were higher, then State and local governments could try to negotiate better prices for themselves.

So, with that, Mr. Chairman, I will end my remarks. And I look forward to your questions. Thanks.

Mr. STEARNS. Thank you. Mr. Ogden.

STATEMENT OF JOHN OGDEN

Mr. OGDEN. Yes. Good morning. Before I begin, I'd like to introduce Mr. Mel Noel. Mr. Noel is an attorney who is also an expert on the drug pricing sections of Public Law 102–585 as well as all aspects of the federal supply schedule process.

Mr. STEARNS. Welcome.

Mr. OGDEN. I am pleased to have this opportunity to discuss with you today the potential effect on VA of opening the pharmaceutical federal supply schedule to State and local entities.

Currently, the Veterans Health Administration expends $1.5 billion annually on pharmaceuticals and related medical supplies. Approximately three-quarters of our drug expenditures are for pharmaceuticals for outpatient veterans. As the Veterans Health Administration reinvents itself to provide health care in a primary/ambulatory care-based model, the amount of our health care dollars expended for pharmaceuticals is anticipated to increase based on increased utilization of pharmaceuticals in the ambulatory care setting.

Therefore, any additional increases in prices paid for pharmaceuticals caused by the potential cumulative effects of opening the FSS schedules to State and local governments could interfere with our ability to care for eligible veterans.

No one can predict with certainty what would happen to VA's contract pharmaceutical prices if those prices became available to State and local governments. The collective concern of VA officials involved in the management of the pharmacy benefit is that opening the FSS for pharmaceuticals to non-federal entities could adversely affect the expenditures for pharmaceuticals for not only VA and other federal buyers but also the groups this action is intended to assist.

This concern stems from the price increases we experienced following implementation of the Medicaid rebate drug pricing provisions included in the Omnibus Budget Reconciliation Act of 1990. Specifically, the highest increases that we experienced were seen in items that were deleted from the federal supply schedule at that time by pharmaceutical manufacturers after the enactment of OBRA 1990.

Prices for these deleted prices increased on average 80 percent. Prices of items remaining on the FSS increased 14 percent. The cost of items in VA depots at that time increased in price by 12.4 percent. Subsequently, Public Law 102–585, the Veterans Health Care Act of 1992, put an end to the steep and sudden price increases.

Now let's fast forward a little bit today. Conversations with drug manufacturers in the recent past suggest that many non-covered

items under the public law could be removed from the federal supply schedules and prices could be increased on other items not currently capped by the public law if the contracts were open to State and local government entities. The latter action alone could result in a $75 million annual increase in pharmaceutical expenditures for VA.

The 5-year impact of Section 603, the federal drug pricing provision of the public law, has been dramatic. Section 603, federal ceiling price requirements, have resulted in a cost avoidance in pharmaceutical expenditures for VA in excess of $1 billion since its implementation in January 1993. That's VA alone.

Additionally, we believe the following three over-arching facts support our concerns. First, virtually all manufacturers of expensive covered drugs have complied with Section 603 of the public law since its inception. There has been no formal resistance or blocking litigation, thus providing the $1 billion benefit cited earlier.

Secondly, the same pharmaceutical manufacturers and many generic drug producers currently find the federal supply schedule pharmaceutical availability to be an efficient, favored marketing vehicle that encourages pricing which is more favorable than federal ceiling prices and even better than most favored commercial customer prices.

Currently, there are 1,729 covered drugs that are priced below the federal ceiling price as defined in the statute. Additionally, 80 percent of the covered drugs are now single priced by their manufacturers. By that we mean the federal ceiling prices are given to non-VA, DOD, and Public Health Service agencies that are not mentioned in the public law. These agencies benefit from this pricing strategy. Opening up the FSS to State and local entities could result in a two-tiered pricing schedule with higher costs being passed on to non-VA buyers.

Third, as we discussed earlier, we saw that when the Medicaid rebate provisions of OBRA 1990 were enacted with no exemption of FSS sales for pharmaceuticals from the best price calculation, covered drug manufacturers sought to protect their margins whenever possible or wherever possible and removed low-priced items from their federal supply schedule contracts.

If similar tactics are employed in 1997 in response to opening FSS pharmaceutical contracts to State and local entities, just as a new round of FSS contracts are being negotiated for the next 5 years or more, VA alone could suffer an increase in pharmaceutical costs of as much as $250 million per year.

To balance the concerns and uncertainties just described and which echo Ms. Steinhardt's comments and also the GAO report, with the possibility of reducing prices, the administration now supports a limited pilot expansion of access to the pharmaceutical FSS schedule for a 2-year period for HIV and HIV-related therapies.

The administration proposes that VA and HHS evaluate the impact of the pilot program and make recommendations to the administrator of the General Services Administration regarding its continued use or limit expansion to other life-threatening conditions. And, for the record, we have attached the administration's proposal.

And, with that, I'll close my formal remarks. Thank you.

[The prepared statement of Mr. Ogden, with attachment, appears on p. 66.]

Mr. STEARNS. Thank you, Mr. Ogden.

Let me start off with questions to you. Just as a general comment, what I heard was that you presented what the administration is proposing, but I didn't hear that you endorsed it. Is that correct? Correct me if I'm wrong.

Mr. OGDEN. You're directing that comment toward me?

Mr. STEARNS. Yes.

Mr. OGDEN. Yes. I think in my own personal opinion having just looked at that proposal in a cursory fashion over the last 48 hours, I can't say whether I support it or not support it. I think it has some intrigue to me personally in it in regards to what the definition of life-threatening health care conditions are and also, for example, just in the area of HIV.

And when we're talking about treating HIV and HIV-related conditions, we're talking about health care conditions in the area of infections, cancer therapy, pain management, nutritional support, and other conditions with the upper respiratory system, GI problems, and also dermatological problems. So there's a whole bunch of ramifications here that I'd personally need to spend some more time reviewing.

Mr. STEARNS. I appreciate your delicate answer, but wouldn't it be fair to say that if we do this experiment, as suggested by the administration, that, much like the pressure in a balloon, it's going to come out somewhere and it would increase, affect the overall pricing structure within the system? Is that a fair assumption on your part?

Mr. OGDEN. I think that's a fair assumption.

Mr. STEARNS. Yes. Would you agree with that, the rest of the panelists?

Ms. STEINHARDT. Yes. Actually, I was smiling at your metaphor because it's one we've used ourselves. It is sort of like squeezing a balloon, the consequence elsewhere.

Mr. STEARNS. I think that's important to put on the record that it's not so much your personal feeling but your feeling that this could have larger ramifications, and that this experiment, although what it sounds like is perhaps an exploratory way to see what the immediate effect might be. That veterans in themselves might have difficulty getting drugs at the present prices is what I'm hearing.

Mr. Ogden, would it be fair to say that as manager of the federal supply schedule, VA is probably the most knowledgeable Executive Branch office to gauge the effects of changing the rules on access to the supply schedule? If you could just give me a "Yes" or "No"?

Mr. OGDEN. Yes.

Mr. STEARNS. Okay. Is there a substantial risk that it would result in raising VA drug prices, just "Yes" or "No"?

Mr. OGDEN. Yes.

Mr. STEARNS. Do you believe the enactment of this legislation would be beneficial to VA or to the VA pharmacy program, "Yes" or "No"?

Mr. OGDEN. No.

Mr. STEARNS. No? Okay. I think you've answered this already: Would the administration's proposed legislation help the VA keep its drug prices low?

Mr. OGDEN. Would the administration's proposal——

Mr. STEARNS. Yes. Would the administration's proposed legislation help the VA keep its drug prices low?

Mr. OGDEN. No.

Mr. STEARNS. Okay. Let's see. According to a letter submitting the administration's proposal to Senator Campbell yesterday, the administration's legislation is based upon the idea that more advantageous prices could be obtained through expanded buying power. Tell me in your personal opinion what you think of tha idea as it applies to combined federal, state, local pharmaceutica purchasing off the federal supply schedule.

Do you want me to repeat the question?

Mr. OGDEN. Yes, please.

Mr. STEARNS. Let's see if we can adjust it for you. Tell me in your personal opinion what you think of the administration's proposal that they submitted to Senator Campbell yesterday to combine federal, state, and local pharmaceutical purchasing off the federal supply schedule.

Have you seen Senator Campbell's proposal?

Mr. OGDEN. Yes, I have. In a cursory fashion, I've reviewed it.

I think the example that Ms. Steinhardt used a few minutes ago in regards to if the market, the current federal market, changes in regards to the exposure to the contracts that somehow, someway, somewhere, somebody is going to pay for increasing that market share and the federal buyers could be, we could be, affected by that pushing the balloon, in one direction, if you will—it's going to pop out in another direction. And I personally think that we may be the target of that pushing out.

So I think the idea that the combined federal/state purchasing power could be enhanced, I think, is again an intriguing one. When you realize that the States and local entities already, many of them, have group purchasing arrangements, many of them already have contracts, many of them already have access to the Section 602 of the current statute, that's why I feel the way I feel.

Mr. STEARNS. Okay. And my last question is directed to Ms. Steinhardt. The administration proposal would expand FSS purchasing for a broad spectrum of pharmaceuticals to, quote, "a State and department or agency of a State and any political subdivision, including a local government," end quote.

The administration proposal does not appear to limit State and local entities to purchase for their own use or for dispensing drugs in their own facility. Would you agree that the FSS market could expand many-fold under this proposal if we followed the administration's proposal and perhaps State, department, agency, State, any political subdivision, including local government, were involved?

Ms. STEINHARDT. Absolutely. Even if one limited it in a much more narrow way, it would still expand many fold. Even at a much narrower definition, it would expand threefold——

Mr. STEARNS. Threefold?

Ms. STEINHARDT (continuing). From where it is today.

Mr. STEARNS. Well, I appreciate your frank comments.

Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I had an opening statement I'd like to put in the record, if I may.

Mr. STEARNS. Yes, without objection.

[The prepared statement of Congressman Evans appears on p. 30.]

Mr. EVANS. I commend you for holding this important hearing on a variety of issues and commend you specifically for holding the panel on homeless veterans. This is clearly an important issue that has not received as much attention as it should have in the last few years.

I just have one question for the VA. Will VA be able to sustain potential increases, which its own analysis said could result due to allowing state or local purchasers access to the federal supply schedule? And what will it do to either improve its negotiations or find savings to accommodate price increases?

Mr. OGDEN. In regards to or in response to your first question about sustaining our situation, I think obviously if our expenditures for pharmaceuticals go up dramatically, as we are now moving patients and treating patients in an ambulatory care setting, this action will effect our ability to care for eligible—and I'll just give you some numbers.

In fiscal year 1995, the average outpatient drug cost per patient per year was $392; in fiscal year 1996, the average outpatient drug cost per patient per year was $430. We anticipated that kind of increase, as we moved patients from inpatient to outpatient care. And it's going to continue because as we treat patients in an ambulatory care setting, we're going to use pharmaceuticals to treat them. So we anticipate, notwithstanding an increase in prices caused by opening schedules, that we are going to spend more money for pharmaceuticals.

In regards to improving our negotiating capability, again, it goes back to expanding the market share. If the market share goes up for the entire federal sector, including DOD and IHS and the other federal buyers, somehow, someway, somebody has got to pay for that affecting the bottom lines of the pharmaceutical industry.

So my guess is it's not going to improve our negotiating capability. It could hinder our negotiating capability.

Mr. EVANS. So, in essence, you anticipate an increase in per-capita user of——

Mr. OGDEN. Right. And so if we also had an increase in pharmaceutical prices just because of the contractual issues, that may mean and that may equate to us being able to treat fewer eligible veterans.

Mr. EVANS. All right. Thank you, Mr. Chairman.

Mr. STEARNS. Thank you, Mr. Evans.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you. I appreciate the opportunity of attending these hearings, but I have no opening statement and no questions at this time. Thank you.

Mr. STEARNS. Well, thank you. I want to thank the first panel. Appreciate your time. And now we'll go to the second panel.

Mr. STEARNS. We have Dr. Thomas Garthwaite, Deputy Under Secretary for Health, Department of Veterans Affairs. And I understand Dr. Horvath is not here.

Dr. GARTHWAITE. Right.

Mr. STEARNS. And then you will introduce the other people.

Dr. GARTHWAITE. Right.

Mr. STEARNS. We welcome you to the Committee, and we look forward to your opening statements.

Dr. GARTHWAITE. Thank you very much, Mr. Chairman and members of the Subcommittee. My complete testimony has been submitted. I have just a few summary comments.

STATEMENT OF THOMAS GARTHWAITE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GAY KORBER, ASSOCIATE CHIEF, MENTAL HEALTH STRATEGIC HEALTH GROUP, DEPARTMENT OF VETERANS AFFAIRS; AND RICHARD ROBINSON, DEPUTY ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF THOMAS GARTHWAITE

Dr. GARTHWAITE. I am pleased to be here to discuss the legislation that will extend authorities and improve the functioning of VA's homeless program and special programs for Persian Gulf veterans.

At the Subcommittee's request, Mr. John Ogden has discussed issues with regard to the procurement of pharmaceutical products. Dr. Robert Rosenheck will follow this panel and discuss the effectiveness of the homeless programs. With me here at the table are Gay Korber, who is the Associate Chief of our Mental Health Strategic Health Group; and Mr. Richard Robinson, General Counsel's Office, who are knowledgeable in these areas.

We appreciate and strongly support your efforts to consolidate and clarify authority for several VA homeless activities. Your proposal would provide clear authority for VA to furnish care and services to veterans with serious mental illness, many of whom are also homeless, and would replace a patchwork of currently existing program authority. Dr. Rosenheck will discuss the effectiveness of these programs and why they're critical to our continuing efforts to address the needs of homeless veterans.

Another provision of the draft bill would extend VA's homeless provider grant and per diem payment program for 2 years, require VA to formally evaluate the effectiveness of programs established using the grants, and lift caps on the number of grants VA may make to homeless providers for use in funding new service center projects and for the purchase of vans. We strongly support these changes.

This program has been successful in assisting public and nonprofit entities to establish new programs, to furnish supportive services and housing for homeless veterans. We would urge the Subcommittee to consider adding provisions to the draft bill that would allow VA to recapture grant funds from recipients if they cease to continue using facilities established with grant funds for the purpose of assisting homeless veterans.

We also support permanently authorizing VA to furnish veterans with noninstitutional care as an alternative to nursing home care. VA currently uses this authority to furnish many veterans with health-related services through contracts with appropriate public and private agencies. This enables many veterans to continue living in their homes when they would otherwise have to receive care in a much more expensive nursing home setting.

The draft bill also includes provisions pertaining to the care of Persian Gulf war veterans, which we support. It would create a new program under which VA would fund demonstration projects that use novel approaches to treat Persian Gulf veterans with undiagnosed and ill-defined disabilities.

The legislation would authorize demonstrate projects involving up to ten geographically disbursed VA medical centers, specify general treatment approaches for a number of these projects, and establish a process for the selection of these sites.

At present we generally treat Persian Gulf veterans' unexplained illness symptomatically in accordance with accepted medical standards and practice given the limits of scientific and medical knowledge in this area. We agree, however, that some non-traditional modes of medical treatment may indeed play a valuable role in the care and treatment of these veterans.

Importantly, the proposed legislation would provide congressional sanction for use of medical care funds to provide non-traditional, innovative, but scientifically and ethically sound medical treatments to expand and improve our clinical understanding and handling of these patients' complex medical conditions.

The draft bill would clarify VA's authority to provide treatment to Persian Gulf War veterans for conditions that might be associated with the veteran's service. And, finally, a draft bill would clarify VA's obligation to verbally inform and counsel Persian Gulf War veterans concerning the registry examination results themselves.

As I mentioned earlier, we support enactment of these provisions. And we appreciate the Committee's advancing all of these proposals, including the Committee's draft bill.

This concludes our remarks, and we look forward to answering your questions.

[The prepared statement of Dr. Garthwaite appears on p. 44.]

Mr. STEARNS. Thank you, Dr. Garthwaite.

Do you mind just introducing the two people that have accompanied you?

Dr. GARTHWAITE. Gay Korber from our Mental Health Strategic Health Care Group and Rich Robinson from our Office of General Counsel.

Mr. STEARNS. Welcome. The first question I have for you is I appreciate, first of all, your positive statement on our draft bill. Given the budget pressures that the VA faces—and we do this every year up here—what kind of impact would additional drug costs of up to $250 million or even $150 million have on the VA?

Dr. GARTHWAITE. That would have a profound effect on the number of veterans we could treat.

Mr. STEARNS. Can you give percentages?

Dr. GARTHWAITE. Just do relatively simple mathematics. The complete care on average for an ill veteran over the course of a year is around $5,000.

So if I did the calculations on the effects of the previous drug legislation, that $75 million range that it cost us before the correcting legislation, we're talking about 15,000 veterans not being able to get care. So for a larger number, it's a larger number of veterans.

Mr. STEARNS. This is a more difficult question: If we had a $250 million increase in additional drug costs, what would that mean per veteran? I mean, is there any way you can put this to a down-home personal level to a veteran? I mean, what kind of additional costs would the average veteran——

Dr. GARTHWAITE. That's 50,000 veterans essentially we would be unable to give care to.

Mr. STEARNS. So 50,000 veterans we would be unable to give care to?

Dr. GARTHWAITE. These would be sick veterans because that's our average cost for the veterans that we are treating. Since it's an average cost, it would have a significant effect.

Mr. STEARNS. Very significant. Without putting words into your proposal today, my observation is that you're basically not fully supportive of this demonstration program. Would that be, in effect, an accurate statement on my part?

Dr. GARTHWAITE. I think the way I look at this is that we have articulated the view from the VA perspective.

Mr. STEARNS. That's a better way of putting it.

Dr. GARTHWAITE. We have articulated the view and the effect on veterans and the view from the VA Department. The administration looks at a much broader picture that includes others. My concern is the presumed savings from an enactment of such a bill——

Mr. STEARNS. Presumed.

Dr. GARTHWAITE (continuing). Would go to someone else. And if there were actual increases, they would come to the VA.

You know, if part of the savings then from the savers came to the VA to offset any increases, then I think that's a different story. But if the net result is that money leaves our pockets and savings are accrued somewhere else, the people that are affected are those 50,000 veterans who don't get care or whatever number that might be. And that's our concern.

If the view from a different place is that overall there might be savings to the Government, that's a different perspective. And we are pleased that this is limited to an experiment of smaller proportion of possible pharmaceuticals so that the number of veterans potentially affected by this would be minimal.

Mr. STEARNS. To your knowledge, how extensive an opportunity did VA have to study the specific proposal on which Mr. Ogden testified before it was adopted as the administration policy? Do you know anything about that?

Dr. GARTHWAITE. If you're talking about the language from the administration recently, we've not had an extensive opportunity to review and comment. As you're aware, it's a very complex issue.

Mr. STEARNS. Oh, I understand.

Dr. GARTHWAITE. And so we've had, really, I think, the language only a couple of days.

Mr. STEARNS. I'm going to follow a little further by saying it. Isn't it OMB's policy to obtain agency comments on administration legislation before it is submitted to Congress? In other words, that's the procedure we understood.

Dr. GARTHWAITE. Usually, yes.

Mr. STEARNS. Yes, usually might be. And if you had been, let's say, fully informed regarding the contents of this proposal and its implications, which you've pointed out and which you've heard from our first panel, would you have advised the Under Secretary for Health or the Acting Secretary? Wouldn't you have given some comments on this legislation?

Dr. GARTHWAITE. I think we have consistently commented from the VA point of view. So I think we've been fairly consistent for a long period of time about our concerns, as Mr. Ogden, I think, very well-articulated in the previous panel.

So I think my answer to you is that we have consistently tried to make people aware of the concerns we have with the effect on veterans. However, we recognize there are other views when you factor in other departments and other parts of government.

Mr. STEARNS. You know, this is just for the record perhaps. This is the opinion of the Chairman. I also think that the price hikes that we've been talking about might result in the States not getting favorable prices either.

Having been in this position—and this is the first position I got elected to—I have seen these types of things, like we pointed out, like a balloon, in which it just goes up and down. And I think one of the things we have some concern about is the implications it would have for the States and the prices that would be affected. You might want to comment on that.

Dr. GARTHWAITE. Well, I am certainly not the expert on all of this, but in several conversations over the last couple of years and especially more recently, I don't think there's anybody that begins to discuss this issue with experts who doesn't walk away with the belief that this is an extraordinarily complex issue.

There are complex interrelationships in law. There are complex interrelationships in the marketplace. There are complex interrelationships in government policies. Predicting if you push here which ones will play out which way I think is very difficult.

We keep going back to the fact that we have one significant experience which was relatively negative to the tune of about $75 million. So that's what's made us especially cautious.

Mr. STEARNS. Thank you. Mr. Gutierrez.

Mr. GUTIERREZ. No questions.

Mr. STEARNS. I want to thank the panel. Appreciate your time. And now we'll go to the third panel.

Mr. STEARNS. We have Dr. Robert Rosenheck, Director, Northeast Program Evaluation Center, Department of Veterans Affairs; accompanied by: Paul Errera, Professor Emeritus, Psychiatry, West Haven VA Medical Center; Robert Piaro, Chairman, Veterans Organizations Homeless Council; and Linda Boone, Executive Director, National Coalition for Homeless Veterans. So we're——

Mr. GUTIERREZ. Mr. Chairman?

Mr. STEARNS. Yes?

Mr. GUTIERREZ. I have to go out and get on a bus to go to the White House to meet with the Vice President. That's why I left a moment ago since some people from the White House wanted to speak to me before I went to the White House. I have to go get on the bus.

So I apologize sincerely since I have to leave. I apologize for not being able to be here.

Mr. STEARNS. Well, thank you for your courtesy and remarks. We will continue.

We want to welcome each of you here. You're our third panel, and you've heard a little bit about what the other two panels have indicated. So at this point let me open it up to you for your comments. Dr. Rosenheck, we'll start with you.

Dr. ROSENHECK. Thank you.

STATEMENT OF ROBERT ROSENHECK, M.D., DIRECTOR, NORTHEAST PROGRAM EVALUATION CENTER, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PAUL ERRERA, M.D., PROFESSOR EMERITUS, PSYCHIATRY, WEST HAVEN VA MEDICAL CENTER; ROBERT PIARO, CHAIRMAN, VETERANS ORGANIZATIONS HOMELESS COUNCIL; AND LINDA BOONE, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS

STATEMENT OF ROBERT ROSENHECK

Dr. ROSENHECK. I'm Robert Rosenheck, Director of VA's Northeast Program Evaluation Center. I'm Professor of Psychiatry at Yale.

Since 1987, I have been responsible for evaluating the several hundred specialized VA programs that provide assistance nationwide to veterans who are homeless and mentally ill. During the past decade, these programs have treated over 200,000 veterans, over 30,000 in the last year.

These programs are unique. They reach out to homeless veterans in places that VA professionals have avoided in the past. For example, in the last 12 months alone, 20,000 veterans have been contacted in shelters and soup kitchens, under bridges, and in airport terminals and bus stations. These programs have widespread impact, increasing interest and concern throughout the VA system for the plight of homeless veterans.

But we do not work alone. Shoulder to shoulder with community partners, VA clinicians are breaking down the mistrust of VA felt by many non-VA agencies. A special program, the CHALENG program, has brought over 3,700 non-VA representatives to work with VA professionals to develop new programs.

The services we provide are diverse. We offered over 6,000 episodes of residential treatment in the last year in over 1,000 VA domiciliary beds and 120 homelike residential treatment facilities.

Just this week, one of the major national mental health journals published a research study showing that over 60 percent of severe alcoholic patients in VA's Compensated Work Therapeutic Residence Program were totally sober during the first 3 months after discharge, their most vulnerable period. The study showed that what helped those veterans stay sober were those elements of the

treatment program that required them to take responsibility for themselves, that required them to work, to pay rent, to have their urine tested for substance use. And these programs are low-cost. At only $19 a day, they are the lowest residential treatment programs in our repertoire.

On an average day, there are 600 VA employees who are graduates of these programs. They have worked their way back into the labor force and joined the VA.

Now, in addition to my job with the VA and as part of it, I'm a Yale professor. And for the past decade, I've been applying the tools of science to the enterprise of helping homeless veterans.

The Congress wrote my job into Public Law 100–6 10 years ago. You did not ask VA just to develop programs for homeless veterans. You asked for programs that work. And every year we publish a report card that goes to every medical center in the country that has one of these programs. It includes 21 measures which address the core performance areas. Every program in the country knows where they stand on these measures.

In our first reports, we showed you that 50 to 60 percent of the seriously mentally ill veterans who completed these programs were well-situated with housing, jobs, and health care when they completed that part of the treatment. And that record has improved over the years. Last year, 45 percent were employed or in training and over 70 percent showed improvement in substance abuse.

In an intensive study published 2 years ago, we followed up 400 veterans with detailed interviews every 3 months for a full year. And we showed that the improvements are long-lasting. We saw 25 percent reductions in psychiatric symptoms, 40 percent reduction in substance abuse, and a doubling of employment.

After the first 2 years of running this program, we summarized our scientific data and brought in a panel of independent outside experts to review our work. They recommended that we strengthen our ties with community providers and with other Federal agencies.

In response, we joined with HUD to develop the largest supported housing program in the nation, linking experienced VA case managers with HUD Section 8 vouchers. And our evaluation shows that this program works, even better then the standard VA program. What we call the HUD VA-Supported Housing Program, HUD-VASH, has 50 percent better housing outcomes than our standard programs.

With the Social Security Administration, we developed a special outreach program for veterans who are ineligible for VA benefits but who qualified for SSI. We increased the award and application rates and cut decision times. And, furthermore, we showed that these desperately needed monetary benefits do not increase substance abuse, even among veterans with severe alcohol and drug programs, but that they do increase the good housing outcomes.

We established a grant and per diem program that received 350 applications from non-VA providers and distributed $17 million to help community providers in 32 States and the District of Columbia expand their programs. These funds will support 1,700 new, supported housing units, 8 service centers, and 3 mobile treatment units. We have expanded our performance-monitoring system so

that our community partners, along with us, can track their results as well, scientifically generating objective documentation that the job they do is well-done.

The homeless problem has not gone away. In 1996, we saw 4,500 more homeless veterans than in 1995. The techniques of modern managed care that you hear so much about will not do for homeless people with severe mental illness.

Behavioral health care firms have not been dealing with homeless mentally ill veterans or with homeless non-veterans, for that matter. In most places, they have left this difficult work exclusively to VA and to our community partners. The practice of clinic-based primary care will just not work for people who sleep on steam grates and who come to the hospital needing so much more than prescriptions and stitches.

I believe we have demonstrated the effectiveness and the high level of accountability that goes with these VA programs. I cannot tell you why, but I can tell you for sure that the triumphs of Wall Street are not changing the situation of homeless veterans on Main Street or Market Street or Broadway.

We are proud of our accomplishments during the past decade and are prepared for the challenge of the next decade. I want to thank you both personally and on behalf of the veterans who have been helped for your commitment to them and for your determination that this job be done and done well. Thank you.

[The prepared statement of Dr. Rosenheck appears on p. 52.]

Mr. STEARNS. Thank you.

Dr. Errera, you were kind enough to come. I want to just give you an opportunity if you want to say any other comments in reference to your colleague's opening statement.

Dr. ERRERA. I'd like to thank you, Mr. Chairman. It was the House Veterans Affairs Committee and your Senate counterparts that created these programs. And you're now helping them mature. All of us are very grateful for that.

Mr. STEARNS. Thank you.

We have now Robert Piaro.

Mr. PIARO. Thank you, Mr. Chairman.

STATEMENT OF ROBERT PIARO

Mr. PIARO. I am presently the Chair of the Veterans Organizations Homeless Council. And at this hearing, I am representing the following veterans' service organizations, which include the Vietnam Veterans of America, AMVETS, The American Legion, The Blinded Veterans Association, Jewish War Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars.

VOHC has met over the last 2 years with the common goal of improving the situation of homeless veterans throughout the United States. VOHC endorses programs and legislation designed to help improve the lives of an estimated more than 250,000 homeless men and women who have served their country in times of peace and war.

As a member of the council, I am exposed to many reports concerning the plight of homeless veterans. Many of these reports deal with the limitations on services either from public social services,

or for those veterans who do not have service-connected disabilities, the U.S. Department of Veterans Affairs.

I am also President and Chief Executive Officer of Veterans Assistance Foundation, a nonprofit (c)(3) that was founded in 1994. The VAF currently receives funds from Wisconsin Department of Veterans Affairs to operate three full-service programs within that State. In this capacity, I and my staff have direct contact on any given day with 90 homeless veterans to provide them shelter, meals, limited counseling, and full-time, nonclinical case management services.

Since accepting the first contract with the Wisconsin Department of Veterans Affairs, our VAF staff have worked in some capacity with more than 2,500 homeless veterans and provided residential services to over 500 veterans at our 3 assistance centers.

As a disabled veteran myself, I have received treatment from various VA centers in nearly 30 years. I have seen the VA system and level and quality of care to the veterans change over the years. I truly wish I could say that all the changes I've witnessed have been for the better. Good and bad programs have come and gone, as have good and bad doctors, medical staff, and so forth. We need to take time to see how the newest change, the VISN networks, will work in the overall program.

Those hit the hardest by the latest changes may be those who were once targeted as high-priority cases: the homeless. Included are veterans who cannot establish a service-connected disability as well as veterans who suffer from chronic substance abuse problems, the lingering effects of PTSD and other mental illness, or a host of other minor physical ailments.

I have been asked to provide testimony on homeless chronically mentally ill, compensated work therapy/transitional residence, the homeless providers and per diem grant, and the VA's contract halfway house program for substance abuse problems.

The foundation runs a program in Madison that has a very close relationship with the Community Support Program, which is called CSP, a facility which is operated under the HCMI Program. The VAF and the CSP staff have worked very closely since the foundation opened in 1996. In fact, the CSP staff has provided office space to VAF since the date of the opening. Likewise, CSP clinicians have provided support services for veterans eligible under HCMI criteria that have been residents in the Veterans Assistance Program. Additionally, CSP staff have provided the means for our staff to access computers regarding veterans as non-compensated VA employees.

The association between CSP and the VAF staff and residents is truly "seamless," a term used in many partnerships between VA and non-VA personnel providing services to disadvantaged veterans. The HCMI staff in Madison is a compassionate group dedicated to helping improve the lives of veterans who place themselves within their care. This program has had nothing but a positive influence on the many veterans it has served, homeless or otherwise, who suffer from chronic mental illness.

Stepping into the other program, which is run by VAF at Fort McCoy, WI, we actively participate at the VAMC Tomah CWT/TR programs. From the beginning, our involvement has been nothing

but a continuing success story on how this program has worked and how it has been getting better every day. The work experience that CWT/TR gives these veterans only helps reinforce their work habits, which leads to gainful employment for the veteran.

There is a continuing need for this program to be funded in order for the veterans to transition into mainstream America with gainful employment. I have no dealings with the VA Transitional Program. So I am unable to address this issue at this time but do support the program for funding.

The homeless provider per diem grant has truly been the one homeless veterans' money available to homeless veteran providers around the country. Each year U.S. DVA is working on making the grant user-friendly, but the biggest worry in our country is the funding of this program. Each year it has declined, down in 1997 to 3.8 million from 5.5 in 1997. This money has made possible community-based organizations and the U.S. Department of Veterans Affairs to perform partnerships all around the country which have proven that they work.

The homeless veterans provider grant per diems are the only truly homeless-specific monies left in America. The funding of this program is the lifeline of the homeless veterans in America.

The DVA's contract program for a halfway house for veterans with substance abuse problems has been a successful program. VAF has seen the effectiveness of this program and has a very good relationship with the VA contract halfway houses. We believe that operation of the VA contract halfway house is a very positive factor in the lives of the homeless veterans in America.

In summary, the above-mentioned programs I have discussed in this testimony should receive recommendations for continued funding and additional funding from the House. There are many veterans in America that depend on these programs.

I very much appreciate the opportunity to provide the testimony in these areas, Mr. Chairman. Thank you for your time.

[The prepared statement of Mr. Piaro appears on p. 58.]

Mr. STEARNS. Thank you.

Our next panelist is Linda Boone. Linda, welcome.

Ms. BOONE. Yes.

STATEMENT OF LINDA BOONE

Ms. BOONE. Mr. Chairman, the National Coalition for Homeless Veterans is committed to assisting the men and women who have served our nation well to have decent shelter, adequate nutrition, and acute medical care when needed. NCHV is committed to doing all we can to help ensure that organizations, agencies, and groups who assist veterans with the most fundamental human needs receive the resources adequate to provide these services to perform this task.

NCHV believes that there is no generic or separate group of people who are homeless veterans as a permanent characteristic. Rather, NCHV takes the position that there are veterans who have problems that have become so acute that a veteran becomes homeless for a time. In a great many cases, these problems and difficulties are directly traceable to the individual's experience in military service or his or her return to civilian society.

It is clear that the present way of organizing the delivery of vitally needed services has failed to assist the 250,000 veterans who are so overwhelmed by their problems they find themselves homeless.

The transmutation of the Veterans Health Administration from a traditional hospital facility-based system into a services-oriented system that is organized into the 22 divisions has produced significant reduction in services needed by many veterans, particularly homeless veterans.

NCHV recognizes the significant effort that the VA has demonstrated in addressing the needs of the homeless veterans in the past few years. We know of many extremely dedicated employees within the VA that go well beyond their normal workday to volunteer in community activities and often provide leadership to expand services to homeless veterans.

The reduction and curtailment of services are perhaps the most drastic in neuropsychiatric care, which concerns NCHV. Inpatient care for post traumatic stress disorder has been drastically reduced in both duration and availability. Many mental health and substance abuse treatment programs have been eradicated, effectively eliminated, or drastically truncated. For example, in VISN I, the New England area, a substance abuse inpatient program went from 21 days to an outpatient 5-day, 8 hours per day program.

NCHV strongly supports the portion of this bill requiring each medical center to make an assessment of needs and services available. We would further request establishment of specific requirements or expectations for each vision to participate in homeless veterans initiatives.

A February 7, 1996, report on the fiscal year 1995 end-of-the-year survey in homeless veterans in VA inpatient and domiciliary care programs done by the NEPEC organization within the VA found 23 percent of all inpatients had been homeless at the time of their admissions. Currently, with the exception that each medical facility have a homeless coordinator, participation by the individual VA medical centers is voluntary for homeless initiatives. This seems a gross neglect of almost one-fourth of the patients in the VHA.

Additionally, as further noted in the NEPEC report, this population is more likely to need inpatient care admission to get their treatment started.

With these significant cuts occurring throughout the nation, we urge this Committee to examine the strategy of reinvestment of the perceived savings achieved through the reordering of the way health care services are delivered. Specifically, we would like to see language to assure that a portion of those resources saved are reinvested to meet the unmet needs of homeless veterans, not simply reassigned to some other type of care. We believe a required percent reinvestment should be set forth in the program dollars that have already been cut and will be cut in each division.

Many community-based organizations, or CBOs, have a strong record of performance in the delivery of services to homeless veterans and could do a great deal more in patient care if resources were available to meet those unmet needs of veterans. CBOs are a vital link in any continuum of care chain, particularly in an era

where there is such concern toward finding the most cost-effective means possible for meeting the vital needs of veterans in each community while preserving the highest standard of quality care.

Traditionally, the VA has been reluctant to contract out delivery of health care services. However, it is clear that the old paradigms do not apply in this rapidly changing environment. The VHA must do what it does best: providing front-line clinical support and channeling resources to the CBOs to do what they can do best. Therefore, we support this portion of the bill that allows contracting with community-based organizations for services.

Additionally, the management assistance committees, the MACs, and the VISNs must include representatives from the community-based organizations that provide direct services on a regular daily basis to veterans who are homeless.

NCHV also supports the continuation of the Homeless Veterans Comprehensive Services Act, which is the grant per diem as proposed in this bill. This program has provided the needed resources for programs to get started that might never have had an opportunity otherwise. We would like to see authorization language that sets an amount to be granted each year delineating the separate amounts for the housing acquisition and amounts for supportive services.

NCHV agrees with the intent of this legislation, and we look forward to working with this Committee and the staff securing needed resources for veterans that are homeless.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Boone appears on p. 62.]

Mr. STEARNS. Thank you, Ms. Boone.

Let me just go to sort of the end of your opening statement. The draft bill we have under discussion awards grants to contract with and work in partnership, partnership with community-based organizations. Would it be fair to say that you support the bill and you don't have any fundamental problems with our bill?

Ms. BOONE. There are some technical issues that we're working on and we're going to be submitting to the staff, but in general we support the intent of this, yes.

Mr. STEARNS. So there are some technical things that you would like to work with our staff on?

Ms. BOONE. Right.

Mr. STEARNS. Dr. Rosenheck, this may be a question for you. You've heard Ms. Boone's testimony that veterans would be better served if VA limited its direct efforts and channeled more money to community organizations to provide services to the homeless. I'd be curious what your response would be.

Dr. ROSENHECK. We have worked for the past 10 years to develop the partnership, and we have succeeded in that. One of the problems that has been well-known for the past 30 years is service system fragmentation, that if you have separate funding streams to the housing agency, to the public support agency, to nonprofits, to VA, totally independent, you get everybody operating as an independent operator. And you get chaos for the clients because they have to get one thing from the VA, one thing from the community provider.

What we have constructed over the past 10 years is teamwork. By channeling funds through VA—and a large proportion of our budget goes to CBOs—we have developed teamwork. And so the fact that we do outreach shoulder to shoulder along with the CBOs strengthens the work of both groups.

So my sense is that what we have developed is a team with complementary roles, but we also have overlapping roles. And the teamwork is one of the great accomplishments of this effort.

Mr. STEARNS. Well, you heard Ms. Boone's testimony that the VA's, quote, "present way of organizing delivery of services has failed to assist" at least the 400,000 veterans who are homeless for at least part of the year. You know, I think that's a pretty clear statement on her part.

Dr. ROSENHECK. Yes. I think there are two issues. Of course, funding limitations mean that we can't treat all of these veterans. The ones we have treated we have demonstrated scientifically are getting effective treatment.

That there is need for additional resources, that there are underserved veterans, severely disabled, there is no question. But I would strongly reject the conception of the community-based organizations operating in opposition or in alternative to the VA and emphasize the achievement that we have enjoyed in the partnership with the national coalition, which has been vastly strengthened in the last 5 years so that we are working together on these problems, enhancing each other's effectiveness and efficiency.

Mr. STEARNS. Dr. Errera?

Dr. ERRERA. Yes. I would like to elaborate on that. I was surprised by Ms. Boone's comment because we have worked well together.

I want to emphasize that most of these veterans have chronic illnesses: medical, psychiatric, substance abuse. Those that don't, many of them have serious behavior problems, anger management. And these need to be addressed by professional people.

There are many facets of the work that can be done and are best done by community-based organizations. Mr. Piaro described the kind of collaboration that they have. And Ms. Boone knows of the collaboration that takes place.

So I would strongly disagree that we haven't been able to do it. I think we do do it together. And this is what VA does best, is work with chronic illnesses.

Mr. STEARNS. Ms. Boone, do you reject partnership arrangements with the VA?

Ms. BOONE. No. Some of our membership has had very successful relationships with the VA in some of their homeless programs. The problem is that the VA is perceived in the community as being everything to all veterans. And our veterans get turned away from community-based services on a daily basis because the myth is that the VA takes care of veterans. And they can't take care of all of the veterans. They don't have those resources.

And the VA only has 172 hospitals and I don't know how many clinics now. So they can't be everywhere, but they certainly have the resources and the charge to help veterans.

So we would like to see them working in expanding the services. And that certainly does take more resources in some cases. But

what we're real concerned about is that veterans are not being served because people perceive that the VA takes care of them.

When Dr. Rosenheck talked about they served 30,000 veterans last year, well, that doesn't quite cut it when there are 275,000. So we would like to see some stepped-up effort to really end this problem.

Mr. STEARNS. You know, in your testimony you mentioned many community-based organizations have a strong record of performance. Do you have any documentation that you could provide us with results?

Ms. BOONE. I guess what I would ask is when the VA compares the cost analysis for services rendered, if they've done any comparisons in the communities. We have not done any major studies. We don't have the resources to do those kinds of studies. So we have not done that.

On an isolated basis, our members do do some of that data collection, but we have not compiled it in a reportable form.

Mr. STEARNS. Mr. Piaro?

Mr. PIARO. Yes?

Mr. STEARNS. Do you wish to comment?

Mr. PIARO. Yes. I understand some of Ms. Boone's concerns, but I believe a lot of this basically when she's making some statement that the general public does perceive the VA to be all to all veterans, which it is not.

But, again, too, I don't think laying that back on the U.S. Department of Veterans Affairs is a true statement. That is a job of the community-based organization to access those services that the VA can't do for that veteran. To lay it all on them I think is impractical.

In our times, we can't expect one agency to foot the bill on everything. You know, it's a collaborative partnership between the communities, State, Federal, and that.

And in my experience in the programs that I have run, it has been very successful. Yes, there have been problems, but there are always going to be problems. But the main thing is as long as we can have an open-door policy, which we have had with the U.S. Department of Veterans Affairs, with HUD and all of these other agencies, it seems to work out. It seems to work out very well.

Mr. STEARNS. So in your opinion, the present situation, status quo is acceptable in terms of how we fund homeless veterans?

Mr. PIARO. Yes except for lack of enough.

Mr. STEARNS. Ms. Boone, how do you feel? You think we should change the process of funding homeless veterans the way we do it?

Ms. BOONE. Right. I think that what the organization believes is that the VA should do more contracting when it makes sense to do that when it can be done. If they can do it in a more cost-effective method, then they should do it. But if a community-based organization can do it in a more cost-effective method and reach more veterans, then they ought to do it.

Mr. STEARNS. Well, that's all the questions I have unless, Dr. Rosenheck, you wanted to follow up with anything.

Dr. ROSENHECK. No. Just to reiterate what we've said, that I think the implication is we would all agree—and I am comfortable speaking for my panelists—that to reach the full extent of the pop-

ulation, we need more funds for the VA as well as one would need more funds for the CBOs. My belief is that the current mix has had a very positive effect on both groups of organizations.

Mr. STEARNS. Well, I thank you.

The staff of the ranking member, any one or two questions you would like to ask before we close? Dr. Cooksey, we'll be glad to hear any questions you may have, too.

Ms. EDGERTON. On a different track, Dr. Rosenheck, if you would answer one question I have about the effects of decentralization? How have your programs' efforts to track spending for the chronically mentally ill been affected by decentralization of both the funding and the management of the VA health care system? And if they have been affected, do you have any thoughts about how you can assure the accountability of mental health programs in this new decentralized era?

Dr. ROSENHECK. The current shift in the VA to a community-oriented system of care, rather than a hospital system of care, is long overdue. As with all transitions, there are dangers. The huge progress we are making is in shifting resources from inpatient units to more efficient outpatient programs that if their intensity is maintained, we have shown scientifically that community-based programs can maintain a high level of outcomes and a high level of efficiency for severely disabled patients.

But there is a risk in any time of change. And the risk is greatest for those who are most vulnerable for those patients who can least speak for themselves and who often are least able to have their needs heard.

We believe that the decentralization holds great promise, but what it has meant is that, instead of the funds being fenced, instead of the funds having to go for these programs, there is latitude to spend them on other programs for other patients.

Now, it is also reasonable, because situations may vary from locality to locality, that there should be decision-making at the local levels, but the only way to assure that the vulnerable do not fall through the cracks in this modified system is to hold the localities accountable.

There are two ways of doing that, two pieces of doing that. One is to continue to collect comprehensive accountability data, which we are doing. But two is to have clear policy from Washington that the localities are responsible for preserving services for the most vulnerable and for preserving high-cost services because in many cases the homeless and the chronically mentally ill need a greater intensity of services, even if it's not hospital services.

So far we have seen substantial commitment from headquarters to support these programs. And so far the data are showing that the programs are largely staying intact.

Some of the issues that Ms. Boone raised, in fact, I think are not problems. She did describe the fact that we are having shorter length of stay in our PTSD programs and that we are having less alcohol inpatient programs, but the PTSD changes came after careful scientific studies that showed that reducing those lengths of stays, shifting those resources to outpatient would not adversely impact the veterans.

These studies need to be ongoing. We need to look to see if veterans are going away from the VA because of these changes. We don't see any evidence of that. So I would say that the moves are constructive, but they need to be carefully monitored. And the values need to be firmly promulgated that these vulnerable populations are special to the VA. And their needs must be addressed.

Ms. EDGERTON. I just have a follow-up question for you. Because you did mention beds, I want to make sure that I understand this. You say 31 percent of those that are receiving inpatient mental health programs are homeless. How can they receive effective treatment if they don't have a supportive living environment while they're receiving outpatient or community-based services?

Dr. ROSENHECK. Well, in fact, they can get some help there because we go to those shelters. Our health care professionals go to those shelters and will bring the veterans personally to the VA.

At the same time, the way we can provide alternative services is by case management, residential treatment, our contracts with our CBO partners, by doing the kinds of programs that we have been running.

Ms. EDGERTON. Thank you, Mr. Chairman. That concludes my questions.

Mr. STEARNS. Well, thank you.

Dr. Cooksey has indicated that——

Dr. COOKSEY. Just 30 seconds. I'm old enough that as I was finishing medical school we were going through that transition when the thorazine and thorazine-like drugs were just coming out and they were opening up all of the mental institutions and turning people out on the streets. Now Prozac is the medication. I feel that there are a lot people out there who need more supervision than just giving them a pill and turning them loose.

My overriding concern is the homeless veterans. And there is no question that a lot of the homeless are veterans. And my other concern is that too often the different agencies work to protect their own fiefdom and don't overlap and help each other more so to the ultimate benefit of the veterans.

We've got to go vote. So thank you.

Mr. STEARNS. I thank my colleague and will indicate that anyone on the panel who wishes to submit questions who is not here is welcome to do so. We thank all of the witnesses for coming today. We know how valuable their time is, their candor and dedication to the VA. And, of course, all of the organizations are doing just very important work.

The subcommittee is adjourned.

[Whereupon, at 10:52 a.m., the subcommittee was adjourned.]

APPENDIX

LUIS GUTIERREZ

SUBCOMMITTEE ON HEALTH OF THE

COMMITTEE ON VETERANS AFFAIRS

HEARING ON RE-AUTHORIZING

EXPIRING LEGISLATION AND VARIOUS ISSUES

JULY 10, 1997

Mr. Chairman, thank you for holding this important hearing today. We have a variety of critical issues to deal with today. I want to make a few brief comments on each of the topics our witnesses will address and then let the experts speak for themselves.

Between 1990 and 1991, VA says Medicaid rebates caused an unanticipated $79 million pharmaceutical price increase to VA. Based on reviewing the testimony of the GAO and analysis by VA it looks as if this may happen again if state and local providers are allowed to make their purchases off of the federal supply schedule VA negotiates for federal providers. Some of us just discovered yesterday that legislation allowing these providers to purchase off the supply schedule is being considered in this Chamber. I am sure that I echo the sentiments of most of the members present today when I say that if I thought this allowance would benefit these providers and not hurt VA, I would be supportive. However, VA knows from past experience that VA does not have enough clout to call the shots with the drug manufacturers, even by adding other purchasers to their market share.

Manufacturers will simply raise their prices for all of us. I am deeply concerned that VA is going to have to absorb costs it did not expect just when the Department's budget is at its leanest. I am ready to act to stop this measure if necessary.

We are also discussing reauthorization of homeless programs. I believe that these homeless provisions are vital to VA's comprehensive approach in treating a highly vulnerable population and I will be happy to support this initiative. Yet more remains to be done. VA needs to ensure that more homeless veterans have access to high-quality programs that meet their many needs. We know that this is a serious issue in this nation. We know that homelessness is not an easy or an inexpensive problem to handle. Yet I believe that you cannot place a dollar value on restoring a veterans' life and making that veteran a healthy and productive citizen again. We need to think seriously on this Subcommittee about how best to ensure optimal access to high quality care for homeless veterans.

We are discussing extending permanent authority to VA providing non-institutional alternatives to nursing home care. I believe that this measure will allow VA to make provision of appropriate and cost-effective health care services possible to a variety of veterans with long-term care needs. VA should be at the forefront of finding solutions to treating older veterans and veterans with chronic health problems in the least restrictive environment. Allowing such treatment will lead to more cost-effective and satisfying care for veterans.

I am also pleased that we are hearing testimony about a new grant program to establish treatment programs for Persian Gulf veterans. These veterans have been suffering too long. We hear more and more evidence that indicates that the symptoms veterans are experiencing as a result of their service in the Persian Gulf are not just in their heads. While we cannot provide them all of the answers they want and deserve today, I truly hope that we can find a way to ensure that veterans will benefit from more innovative and responsive care for their symptoms.

Again, thank you for holding this hearing today, Mr. Chairman. I am looking forward to working with you to pass this legislation.

OPENING STATEMENT OF LANE EVANS

SUBCOMMITTEE ON HEALTH OF

THE COMMITTEE ON VETERANS AFFAIRS

HEARING ON RE-AUTHORIZING

EXPIRING LEGISLATION AND VARIOUS ISSUES

JULY 10, 1997

Good morning, Mr. Chairman. I want to thank you for holding this hearing today. You have asked the witnesses to respond to a variety of proposals and issues today. Many of the initiatives they will discuss—including homelessness—are extremely important in my view and merit more attention from this Subcommittee and our full Committee.

I am extremely concerned with veterans' homelessness in this country. On any given night in America a third of those living on the streets are veterans—many of them are my peers from the Vietnam Era. I find this hard to live with—both as a veteran and as an American citizen—and I believe we must do more to respond to this problem.

Let me say from the start that I appreciate VA's approach to the complicated problem of homelessness. The range of programs VA offers homeless veterans comprise a comprehensive network that meet veterans' needs for

health care, substance abuse treatment, vocational rehabilitation, work and shelter. But access remains a problem—
whole cities are unserved or underserved by VA's homeless programs. So while I appreciate the fact that we are here today to hear from VA and homeless veterans' advocates on the need to extend authorization for some of VA's important homeless programs, I cannot help but add that I believe we must do more to make these programs available to more homeless veterans.

We must also ensure that programs for the homeless are protected while VA undergoes the transition from centralized to decentralized management and funding. In the last session of the last Congress, this Committee supported legislation that required VA to maintain its specialized treatment capacity for some vulnerable populations—the seriously chronically mentally ill many of whom are homeless were one of the populations we specifically wanted to shelter with this law.

We need to be sure that the measures VA uses are reliable and valid indicators that the programs which mentally ill veterans use are available to provide high-quality and timely services to those vulnerable populations. As VA shifts resources from inpatient to outpatient settings and we see inpatient programs that homeless veterans have relied upon—like substance abuse and post-traumatic stress disorder—being dismantled across the

system. In light of these changes, we must ensure that no fewer veterans are treated with at least equal effectiveness in outpatient or community based settings as those treated today.

We have several other important issues to discuss today. I am interested in learning about reactions to a provision Committee staff are developing to create a grant program for VA's Persian Gulf veterans' treatment programs. I am hopeful using this grant approach for funding will allow VA to develop some real centers of excellence and innovation for treatment of veterans' symptoms related to their Gulf War deployment. Seven years is too long to wait to meet the health care needs of these men and women.

Additionally, the option of granting permanent authorization to VA to provide non-institutional long-term care programs will be examined today. The private sector is way out front of VA on this issue and VA must continue to learn from high-quality comprehensive long-term care private sector programs that can document their good results. Almost any veteran would tell you that they want to live at home as long as possible—good non-institutional programs can make this a reality and also save money. If Congress can provide permanent authority, I hope VA will make the most of it to provide higher quality more cost-effective programs like home care, home aides and adult day health care.

Finally, I am very concerned that VA will have yet another unanticipated cost increase, just at a time they it can afford it least. VA pays a billion dollars a year for prescription drugs. Most experts agree that VA has done an excellent job getting the best deal possible for these drugs. VA should be commended for its negotiating skills. Several years ago, VA realized a substantial increase in its pharmaceutical prices due to unanticipated consequences of changes in Medicaid pharmaceutical pricing policies. Our testimony from the pharmaceutical manufacturers' representative states that they would not hesitate to raise their prices again (thus increasing prices VA pays) if state and local purchasers are allowed to benefit from the prices VA negotiates on behalf of federal purchasers. Based on the history of this issue I am anxious to hear the comments of our witnesses about the possible outcomes of extending access to federal supply schedules to state and local providers.

Thank you, Mr. Chairman. This concludes my statement.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 9 30 a m
Thursday, July 10, 1997

FEDERAL DRUG PRICES

Effects of Opening the Pharmaceutical Schedule Are Uncertain

Statement of Bernice Steinhardt, Director
Health Services Quality and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-171

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our recent report on the potential implications for the Department of Veterans Affairs (VA) and other government purchasers of opening the federal supply schedule (FSS) for pharmaceuticals to state and local governments.[1] During fiscal year 1996, the federal government purchased almost $1.3 billion worth of pharmaceuticals from this catalog of drug prices. As you know, schedule prices are often substantially lower than retail prices and are available primarily to federal purchasers. VA used this schedule to purchase about $922 million in pharmaceuticals–about 71 percent of the government's total purchases from the schedule.

In 1994, the Congress authorized the General Services Administration (GSA) to administer a cooperative purchasing program that would allow state, local, and Indian tribal governments, as well as the Commonwealth of Puerto Rico, to purchase pharmaceuticals and other goods and services from federal supply schedules.[2] VA, to which GSA has delegated administration of the pharmaceutical schedule, expressed concern that prices on the schedule could increase if it was opened to a larger group of purchasers. As a result, GSA proposed that the pharmaceutical schedule be excluded from the cooperative purchasing program because GSA did not plan to open any schedule to nonfederal entities if higher schedule prices would result.

Because of concerns about the potential effects of opening more than 140 federal supply schedules, the Congress directed GSA to delay opening any schedule pending completion of our assessment of the potential impact.[3] GSA is currently developing its final implementation plan for opening the schedules.

Today I would like to discuss the factors that could affect schedule price negotiations between VA and drug manufacturers if the pharmaceutical schedule was opened, as well as the opening's potential effects on the schedule prices that would be available to federal, state, and local government purchasers.

To assess the potential impact of opening the schedule, we contacted VA, other federal agencies, and the Congressional Budget Office (CBO). We also contacted the Public Hospital Pharmacy Coalition,[4] the Health Industry Group Purchasing Association (HIGPA),[5] the National Association of Chain Drug Stores, the Pharmaceutical Research and Manufacturers of America (PhRMA), and several drug manufacturers.[6] In addition, we analyzed schedule prices and reviewed assessments made by VA, HIGPA, and the Coalition concerning how opening the schedule could affect schedule and other drug prices.

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[1]Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain (GAO/HEHS-97-60, June 11, 1997).

[2]See the Federal Acquisition Streamlining Act of 1994, P.L. 103-355, sec. 1555 (1994).

[3]See the National Defense Authorization Act for Fiscal Year 1996, P.L. 104-106, sec. 4309 (1996) and accompanying conference report, H.R. Conf. Rep. No. 104-450, at 970 (1996). The implications of opening other schedules are discussed in Cooperative Purchasing: Effects Are Likely to Vary Among Governments and Businesses (GAO/GGD-97-33, Feb. 10, 1997).

[4]The Coalition represents 70 public hospitals that are owned or controlled by state and local governments and serve a disproportionate share of Medicaid and indigent patients.

[5]HIGPA is a national trade association that represents 84 organizations and vendors that purchase pharmaceuticals and other medical products.

[6]The manufacturers we contacted were Eli Lilly and Company; Johnson & Johnson; Merck & Co., Inc.; Pfizer Inc.; and SmithKline Beecham Corporation.

In summary, the effects of opening the pharmaceutical schedule on schedule prices ultimately depend on the outcome of negotiations between VA and drug manufacturers. Because of many uncertainties related to these negotiations, it is not possible to predict how the schedule's prices would change or what the ultimate impact on VA and other government purchasers would be.

Although many factors would influence the negotiations between VA and drug manufacturers, two primary ones are VA's negotiating ability and manufacturers' pricing strategies. Both of these factors would be influenced by the size of the market represented by combined federal, state, and local purchasers that would have access to schedule prices. Moreover, the size of this market could affect the size of any resulting price changes. The larger the market, the greater the economic incentive would be for a manufacturer to raise schedule prices to limit the impact of giving low prices to more purchasers.

At present, federal purchases from the schedule represent about 1.5 percent of the total dollar value of domestic pharmaceutical sales. Estimates of the size of a combined federal, state, and local market, however, vary widely because of uncertainty about which state and local entities would be eligible for schedule prices. If eligibility is not narrowed, VA, PhRMA, drug manufacturers, and the Public Hospital Pharmacy Coalition agree that the size of the combined market could be significantly larger than the current federal market. Although the Coalition estimates that limiting eligibility as it suggests could keep state and local purchases from the schedule at between 0.5 and 4.4 percent of domestic pharmaceutical sales, this would result in a combined market about 33 to 300 percent larger than the federal market.

Federal efforts to lower Medicaid drug prices suggest how opening the schedule could put upward pressure on schedule prices. In 1990, the Congress required drug manufacturers to give state Medicaid programs rebates for outpatient drugs based on the lowest prices they charged other purchasers. Because of the size of the Medicaid market, however, many drug manufacturers sought to minimize the impact of the rebates on their business by raising outpatient drug prices to some private sector purchasers.

If the pharmaceutical schedule was opened to state and local governments and drug manufacturers succeeded in raising their schedule prices in response, the impact on different government purchasers would vary. VA, along with the Department of Defense (DOD), the Public Health Service, and the Coast Guard, would be somewhat protected from price increases because the Veterans Health Care Act of 1992[7] sets maximum prices for these agencies for over one-quarter of the drugs on the schedule. Other federal purchasers would not have that protection. State and local government purchasers, meanwhile, would benefit to the extent that schedule prices were lower than the prices they or their representatives could negotiate with drug manufacturers.

BACKGROUND

The FSS for pharmaceuticals currently contains almost 23,000 products available to federal agencies and institutions and several other purchasers. The purpose of the pharmaceutical schedules, like other supply schedules, is to provide eligible entities an efficient and economical option for purchasing. These entities can purchase pharmaceuticals, however, through other methods. For example, although VA depends on the FSS for most of its drug purchases, VA has awarded several national contracts on a competitive basis for specific drugs it considered to be therapeutically interchangeable.

Under the Veterans Health Care Act of 1992, drug manufacturers must make their brand-name drugs available through the FSS in order to receive reimbursement for drugs

[7]See P.L. 102-585, sec. 603.

covered by Medicaid.[8] The act also requires drug manufacturers to sell drugs covered by the act to four agencies--VA, DOD, the Public Health Service, and the Coast Guard--at no more than 76 percent of the nonfederal average manufacturer's price,[9] a level referred to as the "federal ceiling price" (FCP). A drug's FSS price may be higher or lower than its FCP. If it is higher, the protected purchasers pay no more than the FCP.

GSA published in the Federal Register on April 7, 1995, its initial proposed plan for opening the federal supply schedules to state and local governments. The plan proposed excluding from cooperative purchasing the schedule for drugs and pharmaceutical products and one medical equipment and supplies schedule[10] because GSA concluded that opening them would have the unintended effect of increasing costs to federal users of the schedules. The plan also proposed that participation in the cooperative purchasing program be optional for sellers and purchasers.

IMPACT OF OPENING THE FSS DEPENDS LARGELY ON PRICE NEGOTIATIONS

Price negotiations between VA and drug manufacturers will ultimately determine the extent to which opening the pharmaceutical FSS affects the schedule drug prices available to federal, state, and local governments. Opening the schedule could change the dynamics of negotiating FSS prices for both VA and drug manufacturers. Up to now, VA has been able to obtain significant discounts from drug manufacturers by seeking the most-favored customer price. This price represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions, such as length of contract periods and ordering and delivery practices. Many FSS prices are more than 50 percent below nonfederal average manufacturer prices.[11]

Representatives of several drug manufacturers explained that their companies have been willing to negotiate low FSS prices because they consider the FSS to be a special, limited category of pricing. Representatives of two manufacturers specifically noted that their companies agreed to such prices to help ensure that their drugs were widely used in VA hospitals, where many of the nation's physicians receive part of their training. Some drug manufacturers have indicated an unwillingness, however, to continue to offer such low prices if the FSS is opened to a larger group of purchasers and federal purchasers are combined with other types of government purchasers that the manufacturers have considered to be part of a separate market.

Although VA would be negotiating on behalf of a larger market if the schedule was opened, the increased market share might not in and of itself improve VA's leverage to negotiate lower prices. Drug manufacturers have historically offered different prices for the same product to different purchasers largely on the basis of the purchaser's ability to

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[8]See P.L. 102-585, sec. 603. The act does not cover generic drugs.

[9]The nonfederal average manufacturer price is the weighted average price of each single form and dosage unit of a drug that is paid by wholesalers in the United States to a manufacturer, taking into account any cash discounts or similar price reductions. Prices paid by the federal government are excluded from this calculation.

[10]VA contended that some items on this schedule, which includes in vitro diagnostic substances, reagents, test kits, and sets, could also increase in price if it was opened. The implications of opening this schedule are covered in GAO/GGD-97-33, Feb. 10, 1997.

[11]The cost of drugs covered by the Veterans Health Care Act that had FSS prices below federal ceiling prices as of Sept. 30, 1996, was, on average, 52 percent below the nonfederal average manufacturer price. See GAO/HEHS-97-60, June 11, 1997.

influence drug utilization (sometimes referred to as the ability to move market share).[12] For this reason, volume of sales, while integral to price negotiations between purchasers and drug manufacturers, is not the only important consideration. A common technique used by large-volume purchasers to influence market share is to establish a formulary. A formulary is a list of drugs that a health plan prefers its physicians to prescribe for patients. Drugs are included on a formulary not only for their medical value but also for their favorable prices. Both inclusion of a drug on a formulary and the drug's cost can affect how much it is prescribed and purchased and, therefore, have an impact on its market share. Because formularies have the potential to significantly affect the sales of drugs, large purchasers that use them have greater leverage in negotiating discounts or rebates with manufacturers who want their drugs listed as preferred drugs. However, because the FSS is a catalog of prices, not a formulary, VA lacks that kind of leverage.

If drug manufacturers are unwilling to extend low FSS prices to state and local purchasers, VA could experience a "showdown" with manufacturers over price increases, which it has not experienced before. Drug manufacturers could respond in several ways. First, they could simply refuse to offer their products to state and local purchasers at FSS prices, an option that is permitted under GSA's current proposal. Representatives of several manufacturers told us, however, that they do not consider this option realistic because some competing manufacturers would be likely to offer FSS prices to state and local purchasers, and no manufacturer would want to concede the potential business. Second, drug manufacturers could try to increase FSS prices by raising prices to most-favored customers to change the base on which prices are negotiated with VA. Several manufacturers indicated that this option would depend on the size of the market represented by all government purchasers. Third, drug manufacturers could attempt to negotiate higher FSS prices without linking them to most-favored customer prices. This strategy could result in lengthy, difficult negotiations, which VA has not experienced before with manufacturers.

Size of Market Eligible for FSS Prices Would Be Key Factor

The size of the FSS market if the schedule was opened would be a key factor in determining what would happen to drug prices. The larger the market, the greater the incentive would be for manufacturers to raise FSS prices to limit the impact on their business of giving low prices to more purchasers. GSA's proposed implementation plan for opening the schedules included participation by a state and any department, agency, or political subdivision of a state, including local governments. Representatives of VA, PhRMA, drug manufacturers, HIGPA, and the Public Hospital Pharmacy Coalition agree that unless this definition of an eligible entity is narrowed, the FSS market could expand significantly from its current size of about 1.5 percent of domestic pharmaceutical sales.[13]

The Coalition has suggested that GSA's definition be narrowed to limit access to FSS prices to state and local government entities that purchase drugs for their own use and dispense drugs in their own facilities. The Coalition estimated that defining eligibility this way would result in a state and local FSS market of about 4.4 percent of total dollars in domestic pharmaceutical sales.[14] But the market might actually be considerably

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[12]See CBO Papers: How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry (Washington, D.C.: CBO, Jan. 1996).

[13]According to IMS America, a private vendor of pharmaceutical information, in 1996 the U.S. pharmaceutical market totaled about $85.4 billion in sales, including sales to federal, state, and local government entities. FSS drug sales of about $1.3 billion for fiscal year 1996 represent about 1.5 percent of U.S. pharmaceutical sales.

[14]See PRIME Institute, College of Pharmacy, University of Minnesota, Section 1555 of the Federal Acquisition Streamlining Act: Impact of Cooperative Purchasing on the Pharmaceutical Market, prepared for the Public Hospital Pharmacy Coalition (Washington,

smaller, according to the Coalition, because some state and local purchasers are subject to procurement laws or regulations that would restrict their participation in cooperative purchasing. Also, eligible state and local purchasers would not buy all their drugs from the FSS because it is likely that not all FSS prices would be lower than other prices available to them. If these two assumptions were considered, the Coalition estimated that state and local FSS purchases would fall from about 4.4 percent to 0.5 percent of the total drug market. Therefore, the Coalition's estimates mean that the total FSS market would expand by about 33 to 300 percent if state and local governments are given access to FSS prices.

As for the impact of procurement laws or regulations on state and local participation, 27 of 50 respondents[15] reported in a September 1996 survey we conducted that current state competitive-bidding and other laws would limit their use of federal supply schedules.[16] But most state and local government purchasing officials we contacted indicated that they want the option of purchasing items from the schedules. How many states and localities would change purchasing laws and regulations so that they could participate in the cooperative purchasing program is uncertain. It is also uncertain how many and to what extent eligible state and local entities would choose to buy drugs through the FSS.

Although the size of the combined federal, state, and local market that could have access to FSS prices is unclear, past federal efforts to lower drug prices for a significant market caused many manufacturers to raise prices. Before the Medicaid rebate program was enacted in 1990, state Medicaid programs, which represent about 11 percent of the domestic pharmaceutical market,[17] paid close to retail prices for outpatient drugs. Other purchasers, such as hospitals and health maintenance organizations, paid considerably less. Under the program, the Congress required drug manufacturers to give state Medicaid programs rebates for outpatient drugs on the basis of the lowest prices they charged other purchasers.

After the rebate program's enactment, the prices many large private purchasers paid for outpatient drugs increased substantially.[18] In particular, prices paid by health maintenance organizations rose, on average, more than twice as fast as the year before the program. On the basis of its analysis of these price changes for outpatient drugs, CBO concluded that, because of the size of the market represented by Medicaid, "pharmaceutical manufacturers are much less willing to give large private purchasers steep discounts off the wholesale price when they also have to give Medicaid access to the same low price."[19]

D.C.: Jan. 15, 1997).

[15]Respondents represented 48 states and 2 territories.

[16]See GAO/GGD-97-33, Feb. 10, 1997.

[17]According to IMS America, in 1995 total sales for the U.S. pharmaceutical market were about $77.1 billion. According to the Health Care Financing Administration, Medicaid drug expenditures for fiscal year 1995 totaled about $8.4 billion, including rebates.

[18]See Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (GAO/HRD-93-43, Jan. 15, 1993) and Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals (GAO/HEHS-94-194FS, Aug. 5, 1994).

[19]See CBO Papers.

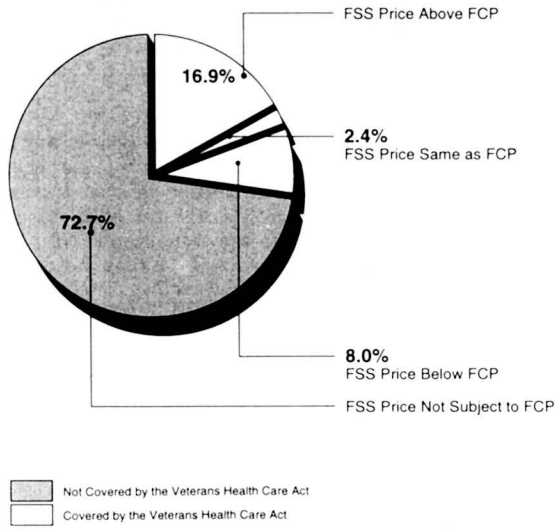
FSS PRICE CHANGES WOULD AFFECT GOVERNMENT PURCHASERS DIFFERENTLY

Although it is uncertain how FSS prices would change if the pharmaceutical FSS is opened, the factors involved in negotiations between VA and drug manufacturers have the potential to produce, in general, an upward pressure on FSS prices.

For VA and Other Federal Purchasers, Impact of Any FSS Price Increases Would Vary

If FSS prices rise after the schedule is opened, all federal purchasers could pay higher FSS prices for many drugs covered and not covered by the Veterans Health Care Act. About 73 percent of the roughly 22,800 drugs on the FSS are not covered by the act.[20] However, these drugs represent a smaller portion of federal expenditures because they are primarily generic equivalents of brand-name drugs. A VA official estimated that about three-quarters of VA's total drug expenditures are for covered drugs. For these drugs, VA and the three other protected federal agencies would not have to pay FSS prices that are higher than the FCPs. But as figure 1 shows, they may have to pay more for the 8 percent of all FSS drugs that currently have FSS prices below their ceiling prices if prices rise to or above the FCPs. The FSS prices for these drugs are, on average, about 28 percent below the FCP.

Figure 1 FSS Price Relative to the FCP for Schedule Drugs as of September 30, 1996



Note: Percentages are based on the number of FSS products, rather than on FSS expenditures.

Source: VA data.

In February 1995, VA presented GSA its analysis of the potential effects of opening the pharmaceutical schedule on FSS prices and VA drug costs, taking into consideration

[20]As of Sept. 30, 1996, the FSS included 22,828 products–6,243 were covered drugs and 16,585 were not covered.

the protection the Veterans Health Care Act provides VA against drug price increases. On the basis of discussions with representatives of numerous drug manufacturers, VA made two key assumptions in its analysis about the potential effects of opening the pharmaceutical FSS: (1) drug manufacturers would eliminate FSS pricing for all drugs not covered by the Veterans Health Care Act, forcing federal purchasers to buy these generic drugs at higher wholesale prices, and (2) FSS prices for all drugs covered by the act would rise to their FCPs.

VA applied those two assumptions to drug purchases it made during the first 6 months of 1994.[21] According to VA, it spent about $37.8 million on 4,877 generic drugs not covered by the act. If it had purchased the same drugs at wholesale rather than FSS prices, VA estimated that it would have paid over $79.7 million, or about 111 percent more. In the same period, VA spent about $118.3 million on 911 brand-name drugs that were covered by the act and that had FSS prices below their FCPs. Had the manufacturers of those drugs raised the FSS prices to their FCPs, VA estimated that it would have paid over $152.9 million, or roughly 29 percent more. Thus, VA calculated that, on an annualized basis, the impact of giving state and local governments access to the FSS would have been a $153.1 million increase in its yearly drug expenditures.

Those federal purchasers that, unlike VA, have no protection from the ceiling prices established by the Veterans Health Care Act would pay full FSS prices on all drugs bought from the schedule. As of November 1996, only 25 of 162 drug manufacturers had FSS prices that were above the FCP. But, manufacturers may offer purchasers not protected by the act prices above the FCP. Representatives of several drug manufacturers told us that their companies would consider this option attractive if the pharmaceutical schedule was opened because it would allow them to offer prices above the FCP to state and local purchasers. Federal purchasers not protected by the ceiling prices would pay the full amount of such price increases.

The potential impact of FSS price increases on different government purchasers when purchasing from the pharmaceutical schedule is summarized in table 1.

[21]According to VA, calculations were based on actual contract purchase prices from VA's prime vendor network from Jan. 1 through June 30, 1994.

Table 1: Potential Effects of FSS Price Increases on FSS Prices Paid by Government Purchasers

Purchaser	FSS price paid		Implications
	Before FSS opened	After FSS opened	
VA, DOD, Public Health Service, and Coast Guard	Lower of FSS or FCP for covered drugs; FSS for drugs not covered	Lower of FSS or FCP for covered drugs; FSS for drugs not covered	FSS price for 8% of drugs could increase up to FCP; FSS price could increase for many drugs not covered.
Other federal government entities	FSS	FSS	FSS prices could increase for many drugs covered and not covered.
State and local government entities	Not applicable–negotiated prices	FSS	FSS prices, even if they increase, could be lower than prior negotiated prices; if they are not, purchasers could try to negotiate lower prices.

Note: For the purpose of this table, federal purchasers are considered to be dependent on purchasing many of their drugs from the FSS rather than from alternative sources.

State and Local Purchasers Could Choose Between FSS and Other Drug Prices

Opening the pharmaceutical schedule would give state and local purchasers the choice of buying drugs from the FSS or from other sources. The Public Hospital Pharmacy Coalition contends that state and local purchasers would benefit from having access to the schedule and manufacturers would have little incentive to raise FSS or other drug prices because

- a manufacturer's participation in the cooperative purchasing program is voluntary, thus allowing a company to opt out of the program if it anticipates any adverse economic consequences;
- if a manufacturer concludes that it must participate in the program for competitive reasons, the same competitive forces will keep prices from rising;
- the potential size of the state and local market will be small, given the Coalition's proposal for determining eligibility to access FSS drug prices; and
- market size is but one of many factors drug manufacturers consider in developing drug pricing strategies.

Assuming negligible adverse effects on FSS prices if the schedule is opened, the Coalition anticipates considerable financial benefits for many state and local purchasers. For example, a Coalition analysis of the differences between FSS prices and the prices nine public hospitals paid for the 100 drugs each hospital spends the most on showed that

FSS prices, on average, were lower than the hospitals' purchase prices for about 83 percent of the drugs.[22] FSS prices were, on average, about 17 percent lower than the prices the hospitals paid.

If the pharmaceutical schedule is opened and FSS prices rise, the extent to which state and local government purchasers could benefit is unclear. The drug prices paid by the hospitals in the Coalition's analysis show that many FSS prices could rise and still be lower than what some state and local purchasers currently pay. If FSS prices remained higher than what state and local purchasers were accustomed to paying, they could try to negotiate better prices for themselves. However, the incentive for a drug manufacturer to negotiate a price below the FSS price would be limited because the negotiated price could become the most-favored customer price and, thus, potentially affect the manufacturer's FSS price negotiations with VA. In any case, VA and other federal purchasers would still face an increase in FSS prices.

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Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or Members of the Subcommittee may have.

(108338)

[22]The analysis was based on FSS and hospital purchase prices as of Oct. 1, 1996.

STATEMENT OF THOMAS L. GARTHWAITE, M.D.

DEPUTY UNDER SECRETARY FOR HEALTH

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

JULY 10, 1997

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here to discuss legislation on the subcommittee's agenda. At the subcommittee's request, Mr. John Ogden, Chief of Pharmacy Benefits and the Strategic Health Group will discuss issues associated with making the Federal Supply Schedule (FSS) available for use by State and local governments, and Dr. Robert Rosenheck, Director of VA Northeast Programs Evaluation Center, will discuss the effectiveness of VA's homeless programs.

The draft bill addresses three different matters. First, it contains provisions that would clarify, consolidate and codify various VA programs to assist homeless and chronically mentally ill veterans. Second, the bill would make permanent VA's authority to provide noninstitutional alternatives to nursing home care. Finally, it contains provisions pertaining to the treatment of Persian Gulf War veterans.

I. HOMELESS PROGRAMS

The draft bill would include several different provisions pertaining to VA's healthcare programs for eligible homeless

veterans. First, it would consolidate and codify in a new subchapter of chapter 17 of title 38, United States Code, authority for several VA homeless activities. It would provide clear authority for VA to furnish care and services to veterans with serious mental illness, many of whom are also homeless. This provision would replace a patchwork of currently existing programs, several of which are authorized in Public Laws, not in title 38, United States Code.

The new authority would replace existing law authorizing VA's contract program for treating veterans with drug and alcohol abuse disabilities in halfway houses and community-based facilities. That program would remain entirely unchanged. It would also codify authority for VA's program for Homeless Chronically Mentally Ill Veterans (HCMI).

Current public law authority for that program would be allowed to expire at the end of this calendar year.

With respect to VA's Compensated Work Therapy/Transitional Residence Program (CWT/TR), it would codify authority for the program in a new section of title 38, which would include most of the provisions currently included in a Public Law provision that now authorizes the program. Of note, it would make the program permanent, lift a cap on the number of facilities VA may operate, and eliminate several unnecessary and unworkable provisions in the Public Law. It would also impose new requirements on residents that they submit to drug testing and require discharge from the

facility for use of illegal substances. Finally, it would retain the requirement that VA use General Post Funds to acquire new properties, but would add a new cap on VA expenditures for facilities at $500,000 per year.

The draft bill would add another new section including provisions that mirror most of the provisions included in the Public Law that authorizes VA's CHALENG Program. It also clarifies VA's authority to work jointly with State and local governments, other Federal agencies, and nongovernmental organizations to assist homeless veterans. It would add new requirements that VA thoroughly evaluate the effectiveness of all of the homeless programs consolidated in the new subchapter. Finally, it would consolidate existing reporting requirements into one annual report addressing all of the homeless programs.

We strongly support the proposed clarification, consolidation and codification of authority. Substance abuse is a significant problem among VA patients, many of whom are also homeless. Approximately seventy percent (70%) of homeless veterans currently treated by the VA suffer from substance abuse problems, while 50 percent (50%) suffer from other serious mental health problems. Some suffer from both. Community-based residential care has long been known to be an effective component in the continuum of care for homeless veterans with substance abuse and psychiatric disorders. It would be appropriate to codify these authorities which specifically target the same subpopulation

of veterans and rely on the same community-based resources to provide the needed long-term medical treatment and rehabilitation.

For those same reasons, it is appropriate to codify VA's authority to provide transitional residential care to participants of VA's compensated work therapy (CWT) program. The CWT program also serves veterans with physical, psychiatric and substance abuse disorders, many of whom are homeless. In fact, at some locations, the CWT program has been integrated into a residential rehabilitation model for homeless veterans. Hence, the authorities at issue here again serve many of the same veterans.

We also support the consolidation of reporting requirements pertaining to programs that serve homeless veterans. Currently, VA must provide reports on different aspects of these programs on different dates. It would be much simpler and more thorough to report to Congress in one single report.

Another provision of the draft bill would extend VA's Homeless Providers Grant and Per Diem Payment Program for two years, while also requiring VA to formally evaluate the effectiveness of programs established using the grants. It would also lift caps on the number of grants VA may make to homeless providers for use in funding new service center projects and for the purchase of vans. We strongly support extending authority for this important program. It has been

successful in assisting public and non-profit entities establish new programs to furnish supportive services and housing services for homeless veterans. We also have no objection to the proposed requirement that VA formally evaluate the effectiveness of the programs funded by these grants. We would urge the subcommittee to consider adding provisions to the draft bill that would allow VA to recapture grant funds from recipients if they cease to continue using facilities established with grant funds for the purpose of assisting homeless veterans.

II. NONINSTITUTIONAL ALTERNATIVES TO NURSING HOME CARE

The draft bill would also include a provision to permanently authorize VA to furnish veterans with noninstitutional care as an alternative to nursing home care. VA currently uses this authority to furnish many veterans with health-related services through contracts with appropriate public and private agencies. This enables many veterans to continue living in their homes when they would otherwise have to receive care in much costlier nursing home settings. We support continuation of this authority which provides an alternative means for providing veterans with a full continuum of care.

III. TREATMENT OF PERSIAN GULF VETERANS

The draft bill includes three separate provisions pertaining to the care of Persian Gulf War veterans. It would create a new program under which VA would fund demonstration projects that use novel approaches to treat Persian Gulf War veterans

with undiagnosed and ill-defined disabilities. An additional goal of the program would be to improve the veterans' satisfaction with the VA care they receive. More specifically, the legislation would require VA to make $5 million dollars available from appropriated funds to establish the demonstration projects at up to ten geographically dispersed VA medical centers. VA would establish the projects no later than July 1, 1998. VA may use any number of different models, but must use three specific treatment models specified in the draft bill. Each of these three models must be used at least twice. They are: a specialized clinic serving Persian Gulf War veterans; a multi-disciplinary treatment approach aimed at managing symptoms; and a case-management approach. The projects may be undertaken in conjunction with DOD pursuant to sharing authority.

The proposal envisions having VA facilities compete to conduct demonstration projects. Before the Secretary could select a site for a demonstration project, a peer review panel would have to determine that the facility's proposal meets the highest competitive standards of scientific merit. The Secretary would also be required to determine that the facility has the ability to attract the participation of clinicians of outstanding caliber and innovation to the projects, and that it has the ability to effectively evaluate the project. Special priority would be given to those facilities which have demonstrated a capability to compete successfully for extramural funding support for

research into the effectiveness and cost-effectiveness of the care provided under the demonstration projects, for example possibly including randomized clinical trials involving health outcomes.

We support this measure, although we do not believe that legislation is necessary to establish the proposed clinical treatment program. At present, we generally treat Persian Gulf War veterans' unexplained illnesses symptomatically in accordance with accepted medical standards and practice, given the limits of scientific and medical knowledge in this area. We agree, however, that some non-traditional modes of medical treatment may indeed play a valuable role in the care and treatment of these veterans. Importantly, the proposed legislation would provide Congressional sanction for use of medical care funds to provide non-traditional, innovative, but scientifically and ethically sound medical treatments to expand and improve our clinical understanding and handling of these patients' complex medical conditions.

Another provision in the draft bill would make a Persian Gulf War veteran eligible for care for <u>any</u> condition that might be associated with the veteran's service in the Persian Gulf. Currently, these veterans may receive care only for disorders that may have resulted from exposure to a toxic substance or environmental hazard. Finally, it would clarify VA's obligation to verbally inform and counsel Persian Gulf War veterans concerning the Persian Gulf Registry examination results.

We support expanding Persian Gulf War veterans' eligibility for priority healthcare because it would allow us to attend to all of their medical conditions that may be associated with their service in the Gulf. In this way, Persian Gulf veterans would receive a more complete and coordinated treatment regimen through a continuum of care. We also agree that it is appropriate for VA to verbally counsel veterans regarding the results of the Persian Gulf Registry examinations.

That concludes my statement. I will be happy to answer your questions.

Statement of
Robert Rosenheck, M.D.
Director, VA Northeast Programs Evaluation Center
before the
HVAC, Subcommittee on Health
July 10, 1997

I am Robert Rosenheck MD, Director of VA's Northeast Program Evaluation Center (NEPEC) and professor of Psychiatry at the Yale University. Since 1987, I have been responsible for evaluating several hundred specialized VA programs that provide assistance to veterans who are. homeless and mentally ill.

Using a well-documented count, based on formal clinical assessments, these programs have treated over 200,000 homeless veterans, thus far, and over 30,000 during the last year, alone. These are unique programs. They are reaching out to homeless veterans in places that VA professionals have not typically gone. In the last 12 month, we reached out to over 20,000 homeless veterans in shelters and soup kitchens, under bridges and in airport terminals and bus stations. This outreach work is difficult, however, we have not gone at it alone. Shoulder to shoulder with community partners we have struggled to overcome the obstacles that exist and to make services available to veterans who have great need of them. A special program, the Community Homelessness Assessment, Local Education and Networking Group (CHALENG) for Veterans Program, was developed to systematically link VA and non-VA homeless service providers at every VA facility in the nation. In 1996, over 3,700 representatives from other Federal agencies, state and local governments and non-profit organizations worked with VA staff to identify the needs of homeless veterans in each community and develop action plans to meet those needs.

The services we provide are diverse. First we offer residential treatment -- over 6,000 episodes in FY 1996 -- to grant a safe haven where healing and rehabilitation can begin. In over 1,000 VA domiciliary beds; in over 120 homelike residential treatment facilities; and in scores of transitional residences we help veterans to regain their health, their confidence and their

hope. We provide medications to ward off frightening hallucinations and morale sapping depression; we provide behavioral weapons for the fight against addiction; and we provide therapeutic work opportunities in special programs some of which are linked to VA owned transitional residences. These programs rebuild a sense of responsibility, pride, and motivation. Just this week one of the major national mental health journals published a research study showing that over 60% of severe alcoholic patients in VA's Compensated Work Therapy/Transitional Residence Program were totally sober during the first three months after discharge -- their most vulnerable period. The study showed that what helped these veterans to stay sober were those elements of the treatment program that required them to take responsibility for themselves -- to work, to pay rent, to have their urine tested for substance use, in addition to therapy. Finally we provide links back to the community -- to real apartments and real jobs. On an average day 600 VA employees are formerly homeless veterans who have worked their way back into the labor force -- and earned jobs with the VA. We do not stop there. We keep in touch with these, now formerly homeless veterans - for months or years -- to keep recovery, rehabilitation and restoration on track.

These are our goals, however, we have to assure that our programs are delivering the services required and accomplishing the desired results.

For the past decade, I have been applying the tools of science to the enterprise of helping homeless veterans. It has been my job to track the outcomes of VA programs that assist homeless veterans. The Congress wrote my job into Public Law 100-6 on February 12, 1987. You said, "Evaluate this program and tell us whether it is effective." Our reports, ten of them, submitted over as many years, have documented what we have accomplished, what we have learned, and how we have used the data to make the program better veteran by veteran, year-by-year.

This has not been an easy task. Social workers under bridges are not always in the best position to fill out data forms. Case managers and residential treatment providers find it unusual to have their patients evaluate their efforts as professionals. And VA administrators had not been used to getting an annual report card showing precisely how they spend the funds they were given for these programs, and how their programs performed in comparison with others around the country. These report cards include 21

critical monitors which address four core performance issues. Are the resources being deployed as intended? Are the veterans seen by the program truly homeless and in medical need? Are they getting the intended services? And are they better when they finish the program? Every program in the country knows where they stand on those measures.

Now, ten years later, after lining up the columns and checking the figures we can say with confidence. -- the job was done -- we did what we said we would do --- services were delivered -- the lives of veterans are better.

In 1987, there was widespread concern about the re-emergence of homelessness in America. How could it be that at a time of economic recovery we suddenly had such an expansion of homelessness? And how could it be that 30% of the homeless were veterans? You didn't wait for an answer to the "why" questions. You said this was wrong and funded a program -- but you did not just throw money at it and leave it at that. You gave us only six months of funds and said, "Show us what you can do -- then we'll see."

We set out to make good on our assignment - beginning in 43 cities. We came back in 6 months and showed you the results -- we had reached out to some 4,000 homeless veterans -- and we showed you that 30%- of them had served in combat -- in World War II and Korea as well as in Vietnam.

These homeless veterans served their country and now they have fallen on hard times. They have serious mental illnesses - 10% have schizophrenia, 10% have PTSD, 50% have substance abuse problems. They are poor – their average income is less than $200 per month. They are alone - over 90% are not married. And they are stigmatized. Over half have been in prison. But they want help. Over 90% say they want what we have to offer them.

In our first reports we showed you that about 50%-60% of the seriously mentally ill veterans who completed our programs were well situated with housing, jobs and health care when they completed the residential phase of treatment. That record has improved over the years. Last year 45% were employed or in training and over 70% showed improvement in substance abuse .

In an intensive study, published two years ago, we followed-up 400 veterans with detailed interviews every three months for a full year after we first met them -- and showed that the improvements we saw at first were

lasting. We saw 25% reductions in psychiatric symptoms, 40% -reductions in substance use, and a doubling of employment.

We also presented detailed cost data an the program. The treatment you funded was not inexpensive. But the veterans we served had been using extensive VA services even before entering our program, even though those services had not gotten them out of homelessness. As a result the incremental cost of the program is relatively modest, about $2,200 per veteran per year.

After the first two years of the program we summarized our scientific data and brought in a panel of outside experts to review our work. They said we had made a good start, but recommended that we strengthen our links with community providers and with other federal agencies. In response, we joined with Department of Housing and Urban Development (HUD) to develop a supportive housing initiative for veterans - linking experienced VA case managers with HUD section 8 vouchers. Our evaluation shows it works. What we call the HUD-VA Supported Housing Program (HUD-VASH) has 5O% better housing outcomes than our standard program.

With the Social Security Administration (SSA) we developed an outreach program for veterans who were ineligible for VA benefits -- but who qualified for Supplemental Security Income (SSI). We doubled the application rate to SSI for this category. And we have shown that these desperately needed monetary benefits do not increase substance abuse - even among veterans with serious alcohol and drug problems -- but that they do increase good housing outcomes.

We established a grant and per diem program and have received 350 proposals during the first 3 rounds of grant applications. We distributed more than $17 million to help community providers in 19 VISNs in 32 states and the District of Columbia established supportive housing and supportive service centers for homeless veterans. These funds will support 1,700 new supported housing beds, 8 service centers and 3 mobile treatment units. In addition, we awarded funding for 20 vans during the first 2 years of the grant program to assist non-VA organizations conduct outreach and provided transportation to homeless veterans. And we expanded our performance monitoring system so that our community partners would benefit from it, as well.

VHA is now changing. Authority is decentralized. Specialization is de-emphasized. Hospital care is de emphasized and outpatient care is becoming the norm in VA, as well it should. Every year we conduct a survey of homelessness among inpatients in the VA system. This year, once again, we found that 31% of all mental health inpatients in the VA system were homeless at admission -- 1,800 veterans every day, although we are now treating far fewer veterans on an inpatient basis. These changes, have significantly increased the need for specialized community-based programs because standard outpatient care is not easy to use if you are homeless. Hospital care, among the homeless was more than just a place to get intensive treatment. It was a place to begin treatment altogether. Assertive community-based treatment, in lieu of hospital treatment, is more important than ever before. Anything less is inadequate.

The homeless problem has not gone away. In FY 1996 we saw 4,500 more homeless veterans than in FY 1995. The need for accountable services, for carefully monitored services, and for community-based services for homeless veterans is greater than ever. Federal and state funding cutbacks have reduced services available from community providers and. bed capacity is being cut back in every health care system in the nation.

Our data suggest that in the absence of systematic community-based outreach services homeless veterans who need effective treatment will not get it. Without such services they will still come to the VA Emergency Room when they are in crisis. And they will still come to the hospital when their conditions deteriorate gravely, but they will be admitted only very briefly, because hospital slays are declining rapidly -- by over 10% in the last year alone. They will come to VA when they are in crisis, and we believe that our community-based services will help them get out of homelessness by providing specialized residential and clinical supports specific to their unique circumstances.

The techniques of modern managed care will not do for homeless people with severe mental illness. Behavioral health care firms have not been dealing with homeless mentally ill veterans, or with homeless non-veterans for that matter. In most places they left this difficult work to VA and to our community partner. The practice of clinic based primary care with its proper emphasis on continuity and accessibility will just not work for people who sleep on steam

grates and who come to the hospital needing more than prescriptions and stitches.

I believe we have demonstrated the effectiveness and the high level of accountability that goes with these VA programs. We have demonstrated a capacity for flexibility, for growth, and for creativity. And we have demonstrated, year after year, the need for these specialized services. I can not tell you why, but I can tell you for sure, that the triumphs of Wall Street are not changing the situation of homeless veterans on Main street, or Market Street, or Broadway.

We are proud of our accomplishments during the past decade and are prepared for the challenge of the next decade. I want to thank you, both personally, and on behalf of the veterans who have been helped, for your commitment to them and for your determination that this job be done -- and done well.

Testimony Presented to
US House of Representatives
Committee on Veterans' Affairs
Sub-Committee on Health
By
Robert R. Piaro, Chair
Veterans Organizations Homeless Council
July 10, 1997

Mr. Chairman and members of the sub-committee, my testimony on US Department of Veterans Affairs (DVA) programs has been requested by the Honorable Cliff Stearns, Chair Subcommittee on Health, US House of Representatives, for the hearing to be held on July 10, 1997. This testimony is specific to VA programs that address the need of homeless veterans and/or veterans who suffer from chronic mental illness.

In accordance with the rules of the House of Representatives, I state that to the best of my knowledge neither I nor any of the organizations, with which I am affiliated receive operating or administrative funds from any Federal grant or contract program at this time nor have we in the past two fiscal years.

Likewise, in accordance with the Rules, I have included the following curriculum vitae for the purpose of the record.

I am presently the Chair of the Veterans Organizations Homeless Council (VOHC) and at this hearing I represent the following veterans service organizations, Vietnam Veterans of America, Inc., AMVETS, The America Legion, The Blinded Veterans Association, Jewish War Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars.

VOHC has met over the last two years with the common goal of improving the situations of homeless veterans throughout the United States. VOHC endorses programs and legislation designed to help improve the lives of an estimated more than 250,000 homeless men and women who served this country in times of peace and war.

As a member of the council, I am exposed to many reports concerning the plight of homeless veterans. Many of these reports deal with the limitation on services either from public social services or, for those Veterans who do not have service-connected disabilities, the US Department of Veterans Affairs.

I am also President and Chief Executive Officer of the Veterans Assistance Foundation, Inc., (VAF) a non-profit 501-(c)(3) corporation founded in 1994. The VAF currently receives grant funds from the Wisconsin Department of Veterans Affairs (WDVA) to operate three full-service homeless veterans' assistance centers in Wisconsin. In this capacity, I and VAF staff have direct contact with up to 90 homeless veterans on any given day providing shelter, meals, limited counseling and full-time, non-clinical case-management services. Since accepting the first contract with WDVA, our VAF staff have worked in some capacity with over twenty-five hundred homeless veterans and provided residential services to over five hundred veterans at our three Wisconsin Veterans Assistance Centers.

As a disabled veteran myself, I have received treatment from various VA Medical Centers for nearly thirty years. I have seen the VA medical "system" and the level and quality of care given to veterans change over the years. I truly wish I could say that all the changes I have witnessed have been for the better. Good and bad programs have come and gone as have good and bad doctors and other medical staff. We do need time to see how the newest change - VISN networks - will work in the overall program.

Those hit the hardest by the latest changes may be those who were once targeted as high-priority cases – the homeless. Included are veterans who cannot establish a service-connected disability, as well as veterans who suffer from chronic substance abuse

problems, the lingering effects of PTSD and other mental illness, or a host of other minor physical ailments.

I have been asked to provide testimony specifically regarding the VA programs Homeless Chronically Mentally Ill (HCMI), Compensated Work Therapy/Transitional Residence (CWT/TR), Homeless providers and Per Diem Grant and the VA's contract program for halfway houses for veterans with substance abuse problems.

The Veterans Assistance Foundation in Madison, Wisconsin, has a very close association with Community Support Program (CSP), a facility which is operated under the HCMI. The VAF and CSP staff have worked very closely since the foundation opened in Madison in April 1996. In fact, CSP staff has provided office space to VAF staff since the opening date. Likewise, CSP clinicians have provided support services for veteran's eligible under HCMI criteria that have been residents of the VAF. Additionally, CSP staff has provided the means for the VAF staff to access computer records regarding veterans as non-compensated VA employees.

The association between CSP and the VAF staff and residents has been truly "seamless," a term used in many partnerships between VA and non-VA personal providing services to disadvantaged veterans. The HCIM staff in Madison is a compassionate group dedicated to helping improve the lives of veterans who place themselves in CSP care. This program has had nothing but a positive influence on the many veterans it has served, homeless or otherwise, who suffer from chronic mental illness.

The VAF Fort McCoy, Wisconsin actively participates in VAMC Tomah CWT/TR programs. From the beginning of the VAF's involvement there has been nothing but continuing success story on how this program has worked and how it has been getting better every day. The work experience that CWT/TA gives these veterans only helps to reinforce their work habits, which leads to gainful employment for the veteran.

In summary, there is a continuing need for the CWT/TR program to be funded, in order for these veterans to transition into main stream America with gainful employment.

I have had no dealings with the VA's Transitional Residence programs, so I am unable to address that issue at this time, but we do support this program for funding.

The Homeless Provider Grant and Per Diem program has been the only true homeless veterans' money available to homeless veterans' providers around the country. Each year DVA is working on making this grant user friendly, but the biggest worry around the country is the funding of this program, each year it has had a declining budget (down in 1997 to 3.8 million dollars from 5.5 million dollars in 1996). This money has made possible Community Based Organization and the DVA to form partnerships all around the country, which has proved that they work.

In summary, The Homeless Veterans Providers Grant and Per Diem Program, are the only true Homeless Veterans specific money left in America. The funding of this program is the lifeline to the homeless veterans in America.

The DVA's Contract Program for Halfway House Care for Veterans with Substance abuse problems, has been a very successful program, VAF has seen the effectiveness of this program and has had a very good working relationships with VA contract halfway houses.

We believe that the operation of the VA contract halfway house is a very positive factor in the lives of many of the homeless veterans in America.

In summary, the above mentioned programs I have discussed in this testimony should receive recommendations for continued and additional funding from the US House of Representatives Committee on Veterans Affairs, there are many veterans in America that depend on these programs.

I very much appreciate this opportunity to provide testimony in the areas requested by the Honorable Mr. Sterns before the US House of Representatives Committee on Veterans Affairs.

U. S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

JULY 10, 1997

TESTIMONY OF
MS. LINDA BOONE
EXECUTIVE DIRECTOR
NATIONAL COALITION *for*
HOMELESS VETERANS

CURRICULUM VITAE

Linda Boone, Executive Director, National Coalition *for* Homeless Veterans took over the management of this national organization in April 1996. Although she is a native of Oregon, she came to DC after two years in Little Rock, Arkansas as executive director of a state wide association of nonprofits.

Linda's efforts for veterans issues started in 1969 as a volunteer in her local community. In 1990 she became aware of the growing crisis of homeless veterans and began her advocacy for these veterans. In September 1993 Linda completed a year as National President of the one-million member American Legion Auxiliary.

FEDERAL GRANT OR CONTRACT DISCLOSURE

The National Coalition for Homeless Veterans has not received in Federal funding in FY97 (Oct. 1, 1996- Sept. 30, 1997) to date.

In FY96, NCHV received $4, 999 from the Department of Veterans Affairs for a *"Stand Down 94 Survey"*.

In FY95, NCHV received $228,232 from the Department of Veterans Affairs as a sub-grantee for an AmeriCorps project for homeless veterans.

Chairman Stearns and Committee members:

The National Coalition for Homeless Veterans (NCHV) is committed to assisting the men and women who have served our Nation well to have decent shelter, adequate nutrition, and acute medical care when needed. NCHV is committed to doing all we can to help ensure that the organizations, agencies, and groups who assist veterans with these most fundamental human needs receive the resources adequate to provide these services to perform this task. Our veterans served us faithfully, often heroically. Each of us can do no less than to do our part to ensure that these men and women are treated with dignity and respect.

NCHV believes that there is no generic and separate group of people who are "homeless veterans" as a permanent characteristic. Rather, NCHV takes the position that there are veterans who have problems that have become so acute that a veteran becomes homeless for a time. In a great many cases these problems and difficulties are directly traceable to that individual's experience in military service or his or her return to civilian society.

The specific sequences of events that led to these American veterans being in the state of homelessness are as varied as there are veterans who find themselves in this condition.

Given our clear and unshakable obligation as Americans to our veterans, we must find ways to do a better job with diminishing resources.

It is clear that the present way of organizing the delivery of vitally needed services has failed to assist at least the 400,000 veterans who are so overwhelmed by their problems and difficulties that they find themselves homeless for at least part of the year (an estimated 275,000 on any given night), not to mention the many thousands more who have not yet reached bottom.

The transmutation of the Veterans Health Administration of the United States Department of Veterans Affairs (VA) from a traditional hospital facility-based system into a "services oriented" system that is organized into the 22 "Veterans Integrated Services Networks" (VISNs) have produced significant reductions in services needed by many veterans, particularly homeless veterans.

The reductions and curtailment of services are perhaps most drastic in neuro-psychiatric care. Inpatient care for Post Traumatic Stress Disorder (PTSD) has been drastically reduced in both duration and availability. ***Many mental health and substance abuse treatment programs have been eradicated, effectively eliminated, or dramatically truncated.***

NCHV strongly supports the portion of this bill requiring each medical center to make an assessment of needs and services available. We would further request establishment of specific requirements or expectations for each VISN to participate in homeless veteran initiatives. In the February 7, 1996 report on the *FY95 End-of-Year Survey of Homeless Veterans in VA Inpatient and Domiciliary Care Programs,* done by NEPEC, found "23% of all inpatients had been homeless at the time of their admissions". Currently, with the exception that each medical facility have a homeless coordinator, participation by individual VAMC is voluntary for homeless initiatives. This seems a gross neglect of almost one-fourth of the patients within the VHA. Additionally as further noted in the NEPEC report, this population is "more likely to need inpatient admission to get their treatment started".

With these significant cuts occurring throughout the nation we urge this committee to examine the strategy of "reinvestment" of the "savings" achieved through the reordering of the way the health care services are delivered. Specifically we would like to see language to ensure that a portion of those resources saved are reinvested to ***meet unmet needs***, not simply reassigned to some other type of care. We believe a required percent reinvestment should be set forth from the program dollars that have been and will be cut in each VISN.

Many community based organizations (CBOs) have a strong record of performance in the delivery of services to veterans in the most vital need, and could do a great deal more inpatient care if the resources were available to meet those unmet needs of veterans. CBOs are a vital link in any continuum of care chain, particularly in an era when there is such concern toward finding the most cost effective means possible for meeting the vital needs of veterans in each community, while preserving the highest standards of quality care.

Traditionally, VA has always been reluctant to contract out any delivery of health care services, except with Medical Schools. However, it is clear that the old paradigms do not apply in this rapidly changing environment. No longer can the VA be all things to all veterans, fulfilling every role. The VHA must do what it does best, providing front line clinical support, and channel resources to the CBOs to do what they can do best. Therefore we support the portion of this bill that allows contracting with community-based organizations for services.

Additionally, the Management Assistance Committees (MACs) in the VISNs must include representatives from the community based organizations that provide direct services on a regular daily basis to veterans who are homeless. Given that at least a fourth of the patients in the VA hospitals are veterans who either are homeless or at risk of becoming homeless, it would seem to be a prudent step to at least solicit the thoughts of the service providers by appointing them to the MAC in each and every VISN.

NCHV also supports the continuation of the ***Homeless Veterans Comprehensive Services Program Act of 1992*** as proposed in this bill. This program has provided the needed resources for programs to get started that might never have had an opportunity otherwise.

NCHV agrees with the intent of this legislation and we look forward to working with this committee and the staff on securing needed resources for veterans that are homeless.

Mr. Chairman, thank you for this opportunity.

STATEMENT
OF
JOHN E. OGDEN, M.S., FASHP
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

JULY 10, 1997

Mr. Chairman and Members of the Subcommittee:

I am pleased to have this opportunity to discuss with you today the potential effect on VA of opening the pharmaceutical Federal Supply Schedule (FSS) to state and local entities.

Currently, VHA expends $1.5 billion annually on pharmaceuticals. Approximately three quarters of our drug expenditures are for pharmaceuticals for outpatients. As VHA reinvents itself to provide health care in a primary/ambulatory care base model, the amount of our health care dollar expended for pharmaceuticals is anticipated to increase, based on increased utilization of pharmaceuticals in the ambulatory care setting. Therefore, any additional increases in prices paid for pharmaceuticals caused by the potential cumulative effects of opening the Federal Supply Schedules to state and local governments could interfere with our ability to care for eligible veterans.

No one can predict with certainty what would happen to VA's contract pharmaceutical prices if those prices became available to state and local governments. The collective concern of VA officials involved in the management of the pharmacy benefit is that opening the FSS for pharmaceuticals to non-federal entities could adversely affect the expenditures for pharmaceuticals for not only VA and other Federal buyers, but also the groups this action is intended to assist.

This concern stems from the price increases we experienced following implementation of the Medicaid Rebate drug pricing provisions included in the Omnibus Reconciliation Act of 1990 (OBRA'90). Specifically, the highest increases were seen in items that were deleted from the FSS by pharmaceutical manufacturers after the enactment of OBRA'90. Prices for those deleted products increased, on average, 80 percent. Prices of items remaining on the FSS increased 14 percent. The cost of items in VA depots increased in price by 12.4 percent. Subsequently, P.L. 102-585, the Veterans Health Care Act of 1992, put an end to these steep and sudden price increases. Conversations with drug manufacturers suggest that many non-covered items could be removed from the FSS and prices could be increased on other items not currently capped by P.L. 102-585. The latter action alone could result in a $75 million annual increase in pharmaceutical expenditures for VA.

The five year impact of Sect. 603, the federal drug pricing provision of P.L. 102-585, has been dramatic. Sect. 603's federal ceiling price requirements have resulted in a cost-avoidance in pharmaceutical expenditures for VA in excess of $1 billion since its implementation in January 1993.

Additionally, we believe the following three overarching facts support our concerns. First, virtually all manufacturers of expensive covered drugs have complied with the Section 603 of P.L. 102-585 since its inception. There has been no formal resistance or blocking litigation, thus providing a $1 billion benefit cited above.

Second, these same pharmaceutical manufacturers and many generic drug producers currently find the FSS pharmaceutical schedule to be an efficient, favored marketing vehicle that encourages pricing which is more favorable than Federal Ceiling Prices (FCP) and even better than most favored commercial customer prices. Currently, 1729 covered drugs are priced below FCP. Additionally, about 80% of covered drugs are single-priced by their manufacturers,

i.e., FCPs are given to non-VA, DoD and PHS agencies that are not mentioned in the Public Law. These agencies benefit from this pricing strategy. Opening up the FSS to state and local entities could result in a two-tiered pricing schedule, with higher costs being passed on to non-VA buyers.

Third, as discussed earlier, we saw that when the Medicaid Rebate provisions of OBRA'90 were enacted with no exemption of FSS sales from the "best price" calculation, covered drug manufacturers sought to protect their margins wherever possible and removed low priced items from their FSS contracts. If similar tactics are employed in 1997 in response to opening FSS pharmaceutical contracts, just as new FSS contracts are being negotiated for the next five or more years, VA alone could suffer an increase in pharmaceutical costs of as much as $250 million per year.

To balance the concerns and uncertainties just described (some of which have been echoed in a recent GAO report) with the possibility of reducing prices, the Administration now supports a limited, pilot expansion of access to the pharmaceutical FSS schedule for a two-year period for HIV and HIV related therapies. The Administration proposes that VA and HHS evaluate the impact of the pilot program and make recommendations to the Administrator of General Services Administration regarding its continued use, or limited expansion to other life-threatening conditions.

Attached for the record is the Administration proposal.

Thank you for the opportunity to present testimony on this subject. I will be happy to respond to your questions.

Sec. Cooperative Purchasing

(a) The following provisions of law relating to cooperative purchasing are repealed:

(1) Section 1555 of the Federal Acquisition Streamlining Act of 1949 (40 U S.C. 481(b)).

(2) Section 4309 of the Clinger-Cohen Act of 1996 (40 U.S.C. 481 note).

(3) Section 9002 of the 1997 Supplemental Appropriations Act for Recovery from Natural Disaster, and for Overseas Peacekeeping Efforts, Including those in Bosnia (Pub. L. 105-18, June 12, 1997).

(b) Section 201 of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481) is amended by adding the following new subsection (b) to read as follows:

"(b)(1) The Administrator shall, as far as practicable, provide any of the services specified in subsection (a) of this section to any other Federal agency, mixed-ownership corporation (as defined in section 9101 of title 31, United States Code), central nonprofit agencies (designated under section 47(c) of title 41, United States Code), or the District of Columbia, upon its request.

"(2)(A) The Administrator may provide for the use of Federal supply schedule contracts of the General Services Administration that fall within the Federal Supply Classification Codes listed in subparagraph (B) by any of the following entities upon request:

"(i) A State, any department or agency of a State, and any political subdivision of a State, including a local government.
"(ii) The Commonwealth of Puerto Rico.
"(iii) the government of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450(e)).

"(B)(i) Subparagraph (A) shall only apply to Federal supply schedule contracts that fall within the following Federal Supply Classification Codes: 36, Special Industry Machinery; 58, Communications, Detection, and Coherent Radiation Equipment (excluding emergency communications equipment primarily used for firefighting, rescue or law enforcement purposes); 65, Medical, Dental, and Veterinary Equipment and Supplies (limited to drugs purchased for the treatment of life-threatening conditions as determined by the Secretary of Health and Human Services and the Secretary of the Department of Veterans Affairs but excluding those drugs used in the general practice of medicine); 67, Photographic Equipment; 70, General Purpose Automatic Data Processing Equipment (Including firmware), Software, Supplies and Support Services; 71, Furniture; 74, Office Machines, Text Processing Systems and Visible Record Equipment; 75, Office

Supplies and Devices; and 99, Miscellaneous (limited only to signs, advertising displays and identification plates).

"(ii) With respect to Federal Supply Classification Code 65, prior to that date which is two years after enactment of this Act, the authority specified in clause (i) shall be further limited to drugs purchased for the treatment of HIV and HIV related conditions as determined by the Secretary of Health and Human Services and the Secretary of the Department of Veterans Affairs During this time, the Secretary of Health and Human Services and the Secretary of the Department of Veterans Affairs shall assess the effect of implementing subparagraph (A) with respect to drugs purchased for the treatment of HIV and HIV related conditions The assessment shall include an analysis of the effect on prices paid by Federal agencies for these drugs. The Administrator shall review this assessment and consider the recommendations of the Secretary of Health and Human Services and the Secretary of Veterans Affairs prior to exercising the authority set forth in clause (i) with respect to drugs purchased for the treatment of life-threatening conditions. In the event of conflicting recommendations, determination of whether to exercise this authority shall be made by the Director of the Office of Management and Budget

"(C) Subparagraph (A) may not be construed to authorize an entity referred to in that subparagraph to order existing stock or inventory from federally owned and operated, or federally owned and contractor operated, supply depots, warehouses, or similar facilities.

"(D) In any case in which an entity listed in subparagraph (A) uses a Federal supply schedule, the Administrator may require the entity to reimburse the General Services Administration for any administrative costs of using the schedule.

"(3)(A) Upon the request of a qualified nonprofit agency for the blind or other severely handicapped that is to provide a commodity or service to the Federal Government under the Javits-Wagner O'Day Act (41 U.S.C. 46 et seq.), the Administrator may provide any of the services specified in subsection (a) to such agency to the extent practicable.

"(B) A nonprofit agency receiving services under the authority of subparagraph (A) shall use the services directly in making or providing an approved commodity or approved service to the Federal Government.

"(C) In this paragraph:

> "(i) The term 'qualified nonprofit agency for the blind or other severely handicapped' means--
>
> > "(I) a qualified nonprofit agency for the blind, as defined in section 5(3) of the Javits-Wagner O'Day Act (41 U.S C. 48b(3)); and
> > "(II) a qualified nonprofit agency for other severely handicapped, as defined in section 5(4) of such Act (41 U.S.C. 28b(4)).

"(ii) The term 'approved commodity' and 'approved service' means a commodity and a service, respectively, that has been determined by the Committee for Purchase from the Blind and Other Severely Handicapped under section 2 of the Javits-Wagner O'Day Act (41 U.S.C. 47) to be suitable for procurement by the Federal Government."

Alan F. Holmer
PRESIDENT

PhRMA

July 8, 1997

The Honorable Cliff Stearns
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
338 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Stearns:

Thank you for your invitation to testify on behalf of the Pharmaceutical Research and Manufacturers of America (PhRMA) at the Subcommittee's July 10 hearing on the possible expansion of the Federal Supply Schedule (FSS) to procurements by state and local government entities. We regret that we cannot testify; PhRMA is unable to address the particular issue the Subcommittee has posed: the likely effects on the Department of Veterans Affairs of such expansion of the FSS. Addressing this question directly requires information about how individual pharmaceutical manufacturers would change their prices for the products they list on the FSS if state and local entities were authorized to purchase at these prices as well as federal government entities. At PhRMA, we have no information or knowledge concerning pricing policies of our member companies. Under antitrust law, we are not permitted to discuss prices; in compliance with its letter and spirit, we do not have such discussions Accordingly, we simply do not know the answer to your question; nor are we able or willing to make predictions regarding your question.

We hope that you understand and appreciate our reasons for declining the opportunity to testify. We do have a number of policy concerns regarding the potential expansion of the pharmaceutical schedule. The enclosed statement, which we ask to be included as a part of the formal record for the hearing, describes those concerns.

Sincerely,

Alan F. Holmer

Enclosure

Pharmaceutical Research and Manufacturers of America
1100 Fifteenth Street, NW, Washington, DC 20005 • Tel: 202-835-3420 • FAX: 202-835-3429

Statement PhRMA

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA

TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS

July 10, 1997

Thank you for the opportunity to express the views of the Pharmaceutical Research and Manufacturers of America (PhRMA) on the possible expansion of the Federal Supply Schedule (FSS) to procurements by state and local government entities. PhRMA opposes expansion of the FSS for pharmaceuticals and supports repeal of Section 1555 of the Federal Acquisitions Streamlining Act of 1994 (FASA), the section of law that would permit this expansion.

In 1997 alone, PhRMA member companies will invest a record $19 billion in pharmaceutical research and development. This investment exceeds 21 percent of their pharmaceutical revenues -- among the highest percentages of R&D of any industry in the United States. With such an extraordinary commitment to innovation, these companies can continue to bring new medicines to market to prevent, cure and better treat diseases. Last year, pharmaceutical pioneers brought 53 new medicines to market for patients suffering from 40 different diseases. These new products, the fruits of biomedical innovation, enable patients all across the country to lead longer, healthier, happier and more productive lives. They also help contain the costs of health care in the United States, including federal programs such as Veterans programs, Medicare and Medicaid, by reducing patients' needs for hospitals, nursing homes, surgeries and other more expensive forms of treatment.

PhRMA believes that expansion of the pharmaceutical schedule of the FSS would be an unwarranted extension of already burdensome government price controls. These controls are arbitrary and for pharmaceutical companies are effectively mandatory and comprehensive, since, under the Veterans Health Care Act of 1992, pharmaceutical firms must list all their products on the FSS if they wish to have any of their products reimbursed or purchased by major federal programs.

On April 7, 1995, the General Services Administration (GSA) published its proposed plan for the implementation of Section 1555 of the FASA. 60 Fed. Reg. 17,764. The GSA determined that it would not be in the best interest of the

Federal Government to open the pharmaceutical FSS to state and local entities. According to the GSA, the combination of (1) unique statutory provisions on pharmaceutical pricing and availability under the Veterans Health Care Act of 1992 (P.L. 102-585) (VHCA), and (2) the proposed cooperative purchasing program, "would have the unintended effect of increasing costs to the Federal users of the schedule." 60 Fed. Reg. 17,765.

The General Accounting Office (GAO) recently completed a study of the potential effects of making FSS prices for pharmaceuticals available to state and local government purchasers (GAO/HEHS-97-60). According to the GAO, the Department of Veterans Affairs (DVA) agreed with the GSA's determination that extending access would increase costs to Federal purchasers (pp. 2, 6). The GAO report indicates that expansion "could produce, in general, an upward pressure on FSS prices" (p.13). All federal purchasers could pay higher FSS prices for drugs not covered by the VHCA (approximately 73 percent of the 22,800 drugs in the schedule) (p. 14). VA and other federal agencies covered by the VHCA could also pay higher prices on the eight percent of all FSS drugs that have FSS prices below the VHCA's ceiling price (p. 15). As a result, VA and other protected agencies could experience price increases for almost 81 percent of the schedule drugs. Under one scenario, VA estimates that giving state and local governments access to the FSS would have increased VA's 1994 drug expenditures by $153 million, which would have been a 49% increase (p.16).

The GAO report also states that the "larger the market, the greater the economic incentive.... to raise prices to limit the impact of giving low prices to more purchasers" (p. 6). According to the report, even under minimal assumptions about the size of the new expanded market, "state and local purchases from the schedule at between .5 and 4.4 percent of domestic sales, would result in a combined market about 33 to 300 percent larger than the federal market" (p. 4). Hence, even under the most conservative assumptions, the economic pressures created by expansion of the FSS would be significant. While PhRMA can't predict what marketing decisions individual companies might make, PhRMA does believe that the GSA and GAO conclusions should be given due consideration.

In addition to the pricing concerns noted by GAO and GSA, PhRMA has significant policy concerns about the expansion of the FSS in the larger context of government health reimbursement, provision and procurement practices. There is a growing number of mandatory government programs and practices that represent serious intrusions into the free market that currently supports our industry's pursuit of innovative pharmaceutical products. These programs include (1) Medicaid rebates, (2) discounts to certain agencies under the VHCA, (3) discounts to Public Health Service grantees, (4) required listing on the FSS for Medicaid reimbursement eligibility, and (5) State Pharmaceutical Assistance Programs, many of which also include rebates. At least 50 million Americans,

roughly 20 percent of the population, have access to pharmaceuticals at government-mandated below-market prices as a result of one or more of these programs. The more broadly these programs are extended, the more the free market for innovative pharmaceutical products is eroded, and the more biomedical innovation is discouraged.

We believe that government health care policies and programs will best serve the interests of the American people if they facilitate the delivery of publicly-financed healthcare through private-sector, market-based plans that encourage competition, provide choices, and promote integrated health care assessment, treatment and budgeting. Policies and programs that satisfy these criteria will promote high quality healthcare for patients, contain healthcare costs, and promote the optimal use of innovative pharmaceutical products.

NATIONAL LAW CENTER
ON HOMELESSNESS & POVERTY

Statement of

Maria Foscarinis, Executive Director
Laurel Weir, Policy Director
National Law Center on Homelessness & Poverty

To the
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives

July 11, 1997

918 F Street NW Suite 412 • Washington, DC 20004 • phone: 202-638-2535 • fax: 202-628-2737

My name is Maria Foscarinis. I am the founder and Executive Director of the National Law Center on Homelessness & Poverty, a not-for-profit legal advocacy group for homeless and poor persons. Laurel Weir is the Law Center's Policy Director. The mission of the Law Center is to advocate for solutions that address the underlying causes of homelessness.

On any given night, there are as many as 775,000 persons who are homeless in the United States. Over the course of a year, as many as two million persons may be homeless. It is estimated that approximately 30% of these persons are homeless veterans. That so many persons who have served their country are today living on the streets is a national shame.

I appreciate the Committee's commitment to re-authorizing the Department of Veterans' Affairs' (VA) programs for homeless veterans and would like to make a few suggestions on how to strengthen the draft bill.

Recommendations

1. Increased Outreach

The outreach language should be strengthened to ensure that all VISNs conduct outreach to homeless veterans. Outreach is important because it connects homeless veterans with services available from the VA. But outreach is also important because it can connect homeless veterans to non-VA resources as well. For example, many homeless veterans are eligible for Supplemental Security Income (SSI) benefits but do not receive it because they do not know about it or are unable, due to mental or physical disability, to negotiate the application and certification process.

SSI benefits can help homeless veterans to obtain needed housing by providing them with an income. Just as important, persons who qualify for SSI are automatically eligible for Medicaid. Both of these programs could provide desperately needed relief to mentally and physically disabled homeless veterans.

Requiring the VA to conduct additional outreach is a cost-effective as well as humane use of funds -- by helping homeless veterans access non-VA services, outreach leverages more than just VA funds to assist homeless veterans.

2. Assessment of Needs

We strongly support the Committee's draft bill requirement in Subsection 1773 that the Secretary require the director of each medical center or benefits office to assess the needs of homeless veterans in the area served by the center or office. We believe this section could be strengthened by the following additions.

First, in addition to the six areas identified for assessment in subparagraph (b)(3), an assessment should also be made as to the eligibility for benefits, such as disability benefits, and the need for legal assistance. As evidenced by several Stand Downs, the provision of legal assistance can sometimes remove barriers to employment, such as an arrest warrant issued because a homeless veteran failed to pay a fine for sleeping in a public park.

Second, the Secretary should require each medical center or benefits office to provide the aggregate data on the numbers and needs of homeless veterans in each area to

local jurisdictions for use in the "Consolidated Plans," which the jurisdictions must submit in order to receive housing, homeless and community development funding from the U.S. Department of Housing and Urban Development (HUD). These consolidated plans set forth the jurisdiction's priorities for use of HUD funds and must include a general assessment of housing and homeless needs within each jurisdiction.

This requirement would raise the visibility of homeless veterans, increase community knowledge of their needs, and increase communication between the VA and local officials responsible for housing and meeting the needs of homeless persons in those jurisdictions.

Third, in jurisdictions where there is a closing military base, the Secretary should require each medical center or benefits office to provide the aggregate data on the numbers and needs of homeless veterans in each area to the Local Redevelopment Authority (LRA) responsible for developing the re-use plan for the base in that jurisdiction. Under a 1994 base closure law, LRA's are required to consider the needs of homeless persons in the vicinity of the base as the LRA develops its reuse plan. The VA should ensure that the needs of homeless veterans are included in that consideration.

3. Cuts in Care

As part of its overall restructuring, many VA facilities have been moving from providing in-patient mental health care to out-patient mental health care. This is likely to be detrimental to homeless veterans. Numerous clinical studies have shown that housing stability is a key component to ensuring effective mental health treatment of homeless persons. The VA should only be allowed to reduce the number of in-patient beds if it ensures that at least an equivalent number of new beds are made available in the community for these veterans and that it ensures transportation and coordination of services for homeless veterans in such community facilities.

4. NIMBY

One of the greatest barriers to the provision of community based services for homeless veterans is the growing prevalence of Not-In-My-Back-Yard (NIMBY) activities. Opposition mounted by prospective neighbors to the siting of housing and services often causes local government entities such as zoning boards to deny or delay granting the permits or variances necessary for the facilities to open. In most cases, this opposition is based on unfounded fears about homeless persons in general and the impact of the existence of a facility rather than any real concerns about the way a particular facility is operated. The impact of these irrational prejudices is significant.

A 1995 Law Center study of 61 programs, located in 36 cities across the country, which faced NIMBY opposition, found that 54% were halted altogether, 15% were still in jeopardy at the time of publication, 3% had been forced to move to another location, and of the remaining 30%, most had experienced costly delays. The Law Center also found that local land use and zoning regulations were the most common methods used by groups to halt projects to assist homeless persons.

Groups that serve homeless veterans are vulnerable to this NIMBY opposition. For example, a group in upstate New York that serves homeless veterans who are recovering from substance abuse has been struggling for almost a year now simply to get a zoning variance to site their facility. The local zoning board will not grant them the needed variance and has specifically noted opposition from some of the neighbors as a reason for the board's denial of the variance. This non-profit group had been awarded both VA and

HUD funds to provide housing and services for homeless veterans, and it is in danger of losing those funds if it cannot start its program soon.

The VA can play an important role in such disputes. The VA should appoint a liaison to help local grantees in such instances and the VA should act as an advocate for such groups. The VA could also help prevent or mitigate some of these problems by conducting proactive outreach to educate local officials about homeless veterans and their needs to minimize unfounded NIMBY opposition.

Additionally, we are concerned that the provisions of Subsection 1772, which sets forth the requirements for therapeutic housing, may leave such housing programs vulnerable to cases of extreme NIMBY opposition because the bill requires the programs to comply with local zoning and provides no alternatives if the locality unfairly denies zoning requests. The bill should be modified to provide the Secretary with additional options in cases where the Secretary has made a good faith effort to work with local government entities but has been rebuffed due to NIMBYism.

Conclusion

Thank you for your consideration. We stand ready to assist you as you go forward with the reauthorization of the VA's homeless assistance programs.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN EVANS TO BERNICE STEINHARDT, DIRECTOR, HEALTH SERVICES QUALITY AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE

1. Ms. Steinhardt, for the benefit of those of us who were not around in fiscal year 1991, will you tell us, from your own perspective, why VA experienced an unanticipated $79 million price increase in its pharmaceutical drug costs?

In 1990, the Congress required drug manufacturers to give state Medicaid programs rebates for outpatient drugs on the basis of the lowest prices they charged other purchasers, such as hospitals, health maintenance organizations, and VA. Before the Medicaid rebate program was enacted, state Medicaid programs paid close to retail prices for outpatient drugs despite representing a significant share of the domestic pharmaceutical market. Other purchasers paid considerably less. After the rebate program's enactment, however, the prices many large private purchasers paid for outpatient drugs increased substantially. Because of the size of the Medicaid market, drug manufacturers were much less willing to give large private purchasers discounts off wholesale price when they also had to give Medicaid access to the same low price. Many FSS prices also increased substantially perhaps because they were low before the rebate program's enactment and FSS prices were initially considered with private sector prices in calculating rebates. Consequently, in the Veterans Health Care Act of 1992 the Congress exempted all drugs prices paid by VA and other federal entities from further rebate calculations.

2. For whom does VA negotiate the federal supply schedule for pharmaceutical drugs? Would you say their negotiations have been successful to date? If so why? Would they be equally successful if VA were to negotiate on behalf of the larger market we are addressing?

In negotiating schedule prices with drug manufacturers for nearly 23,000 pharmaceutical products, VA represents all entities that are allowed to purchase from the FSS. This includes federal agencies and institutions and several other purchasers, such as the District of Columbia, U.S. territorial governments, and many Indian tribal governments. VA has been able to obtain significant price discounts from drug manufacturers, often way below retail or average manufacturer prices, by seeking the most-favored customer price. These discounts are the same ones that manufacturers offer their most-favored nonfederal customers under comparable terms and conditions. Manufacturers have been willing to negotiate such low FSS prices because they consider the FSS market a special, limited category of pricing. Some manufacturers also have agreed to such prices to help ensure that their drugs are widely used in VA hospitals, where many physicians receive part of their training.

Whether VA would be as successful as it has been in obtaining low FSS prices if it were to negotiate on behalf of a larger market would depend on many factors that would influence the outcome of negotiations between VA and drug manufacturers. But the increase in the size of the FSS market from combining government purchasers might not in and of itself improve VA's leverage to negotiate lower prices. As we discussed in our testimony and report, drug manufacturers have historically offered different prices for the same product to different purchasers largely on the basis of the purchaser's ability to influence drug utilization, referred to as the ability to move market share. A common technique used by large-volume purchasers to influence utilization is to establish a formulary, which is a list of drugs that a health plan prefers its physicians to prescribe for patients. However, because the FSS is a catalog of prices, not a formulary, VA lacks that kind of leverage in schedule price negotiations with manufacturers. Further, manufacturers have considered the FSS market separate from other markets in regards to their drug pricing strategies. Therefore, expanding the FSS market to include state and local government purchasers that manufacturers have treated as part of other markets has the potential to change the manufacturers' pricing strategies.

3. Ms. Steinhardt, your written testimony seems to acknowledge that it is quite likely that VA will experience a price increase as a result of allowing state and local purchasers to buy pharmaceuticals from the federal supply schedule. Why was your report less definitive in making this finding?

Both the testimony and report emphasize that the effects of opening the pharmaceutical schedule on schedule prices depend on the outcome of negotiations between VA and drug manufacturers and that there would be many uncertainties related to these negotiations. As a result, it is not possible to predict how schedule prices would change or what the ultimate impact on VA and other government purchasers would be. However, we also note that the factors involved in these negotiations would have the potential to produce, in general, an upward pressure on FSS prices. As described in the testimony and report, these factors include potential change in the dynamics of negotiating between VA and drug manufacturers, continued limitations on VA's leverage to negotiate because the FSS is a catalog of prices rather than a formulary, and uncertainty about the increase in size of the FSS market that would be represented by sales to federal, state, and local government purchasers.

4. You note that several manufacturers told you that they have been willing to negotiate low FSS prices because they consider it a special limited category of pricing. Some acknowledged that they like residents who are training in VA facilities to have experience with these drugs. (In your opinion) How likely are the pharmaceutical manufacturers to continue discounting their prices if large numbers of providers become eligible to make federal supply schedule purchases?

Because of the uncertainties that would be involved in FSS price negotiations between VA and drug manufacturers, it is not possible to predict what pricing strategies manufacturers would adopt if the pharmaceutical schedule was opened to other purchasers. Up to now, VA has been able to obtain low FSS prices without the type of hard-nosed negotiating that is commonplace in the private sector between purchasers and drug manufacturers. However, some drug manufacturers have indicated an unwillingness to continue to do business as usual with VA if the schedule is opened to an expanded group of government purchasers. Moreover, these manufacturers have indicated that they are unwilling to combine different types of purchasers that the manufacturers are accustomed to treating as part of separate markets. The larger the size of the FSS market that would result from opening the schedule, the greater the incentive would be for manufacturers to raise schedule prices to limit the impact on their business of giving low FSS prices to more purchasers.

If FSS prices increased after the schedule was opened, VA, along with the Department of Defense, the Public Health Service, and the Coast Guard, would continue to be guaranteed a discount for drugs covered by the Veterans Health Care Act of 1992. For these agencies, the act sets a ceiling price for brand-name drugs at no more than 76 percent of the nonfederal average manufacturer price. As we reported, FSS prices for many drugs the act covers are well below their ceiling prices. Other federal purchasers, however, would not have a guaranteed discount and would have to pay full FSS prices on all drugs they would purchase from the schedule.

5. Your statement mentions that, because VA does not use formularies, they are not likely to benefit from the type of purchasing leverage from which other large purchasers have benefited in negotiating prices. We understand VA is in the process of establishing formularies, but obviously other providers for whom VA negotiates will not be subject to using the same drugs. Will VA still be able to realize the same savings if they are negotiating for other purchasers who are not subject to using their formulary?

While VA medical centers use formularies, the FSS is a catalog of prices and not a formulary. VA has been successful in negotiating significant FSS price discounts on behalf of all federal purchasers while at the same time attempting to control its own drug costs by using formularies and competitive-based contracts for some drugs. Therefore, VA's use of cost-control methods in addition to purchasing drugs from the FSS has not reduced VA's ability to obtain FSS price discounts for itself and other purchasers.

POST-HEARING QUESTIONS
CONCERNING THE JULY 10, 1997
HEARING ON DRAFT LEGISLATION ON PHARMACEUTICAL PRICES, HOMELESS VETERANS' PROGRAMS, AND ISSUES RELATED TO PERSIAN GULF WAR ILLNESS

FOR THE DEPARTMENT OF VETERANS AFFAIRS

FROM THE HONORABLE CLIFF STEARNS
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

Question 1: Would you expand on your statement that opening the FSS could not only hurt VA but fail to achieve any benefit for the groups sought to be helped?

Answer: My intent in making this statement was to articulate that drug pricing benefits currently accrued by VA and other federal buyers could be adversely affected by pharmaceutical manufacturers removing those items that they could legally remove from the FSS and raising those prices, which are currently below Federal Ceiling Price (FCP), to the FCP. The worst case scenario would be a repeal of the drug pricing sections of P.L.102-585. In each instance, prices for both federal buyers and non-federal authorized buyers would increase. In addition, there are a number of disproportionate share hospitals and federally funded specialty clinics that already have access to P.L. 102-585 drug pricing, many below FSS pricing. These groups would also incur increased prices as the pharmaceutical industry moves to minimize the effect of opening the schedules on their profit margins. For example, a recent review of 25 drug products utilized in the treatment of HIV and HIV-related conditions demonstrated that 14 of the products had prices below the FCP. There is little doubt that the industry would move to raise these prices to the FCP as quickly as possible following the opening of the FSS. Also, some federal buyers who are not currently mandated by statute to receive Federal Ceiling Prices, such as the Bureau of Prisons, would see price increases as the industry moved to increase prices as described above.

Question 2: VA did an analysis in 1995 which concluded that if FSS drug schedules were opened to state and local governments, it would "result in dramatically increased FSS prices," and that VA would experience increased costs of more than $153 million.

(a) On what did VA base its conclusions?

(b) Have you formally or informally updated your analysis? What is our current estimate of increased costs? Would you furnish us your analysis for the record?

Answer:

(a) We based our 1995 conclusions on the effects of opening the FSS to state and local entities, using the following assumptions:

1. All pharmaceutical companies would eliminate FSS pricing where they could legally do so.

2. All FSS pharmaceutical contracts expire on 12/31/95.

3. All covered drugs would be sold at the mandated FCP, none lower.

The calculation of the effect of opening the FSS schedules on VA drug expenditures was based on actual contract purchases as described on the attached analysis.

(b) We have not formally updated our analysis but, as indicated in my testimony, we have informally estimated increased annual expenditures of $250 million. Please note that this estimate includes the fact that all FSS pharmaceutical contracts will expire on 12/31/97. We are currently in the negotiation stage for these contracts for a period of 5 or more years. We think opening the FSS at this time to state and local governments is the worst possible time for such action. If the FSS is open to state and local entities, the pharmaceutical industry will move to protect their profit margins through adjusting prices upward on the next round of FSS contracts.

ATTTACHMENT TO QUESTION 2(a)

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION

Potential Impact of the Federal Acquisition and Streamlining Act (FASA) of 1994 (Public Law 103-355) on Pricing to the Department of Veterans Affairs

Public Law (P.L.) 103-355, Section 1555, granted permission to the General Services Administration to make all Federal Supply Schedule (FSS) contracts available to state and local governments. The passage of this law prompted numerous phone calls and visits from the pharmaceutical industry to the Drug and Pharmaceutical Management Section of the Department of Veterans Affairs (VA). The substance of all of the calls and visits was the same, that is "if FSS contracts for pharmaceuticals were extended to state and local governments, FSS pricing would most likely be eliminated for drugs not covered under P L 102-585, the Veterans Health Act of 1992 Prices on all drugs covered under P.L 102-585 that are currently lower than the Federal Ceiling Price (FCP) would be raised to the FCP " This message was coming from companies such as Smith Kline Beecham, Lederle, Wyeth-Ayerst, Miles, Pfizer, Schein, Rugby, Geneva, and many more. The message from both ethical and generic manufacturers was consistent

Based on these discussions, VA developed and used the following assumptions in its analysis of drug expenditures

1 All pharmaceutical companies would eliminate FSS pricing where they could legally do so.

2 All FSS pharmaceutical contracts expire on December 31, 1995

3 All covered drugs would be sold at the mandated FCP, none lower

4 If pharmaceuticals not covered under P.L. 102-585 were dropped from FSS, VA could purchase these products at wholesale cost.

The calculation of FASA impact on Veterans Health Administration (VHA) drug expenditures was based on actual contract purchases through the VA prime vendor network from January 1, 1994, through June 30, 1994. Non-contract pharmaceuticals, IV solutions, manufacturer direct purchases. and purchases through the VA Depot System, which was phasing down at the beginning of 1994, were not included in the calculation The wholesale drug costs, FCP and FSS contract prices from September 1994 were used for the calculation.

In the targeted timeframe, 4877 unique pharmaceutical products not covered by P L. 102-585 were purchased for $37,785,006 The same items would have cost $79,739,425 if VA had to purchase them at wholesale cost, a difference of $41,954,419 For covered drugs under P L. 102-585, 911 unique pharmaceutical products were purchased at an FSS price lower than the mandated FCP for a total of $118,310,530. If these drugs had to be purchased at the mandated ceiling prices, the cost would be $152,916,153 The total increased drug expenditures for VHA would be $76,560,042 for six months, or an annualized increase of $153,120,084

This estimate does not include potential impact on other Federal agencies such as the Department of Defense, Public Health Service, and the Bureau of Prisons.

111H
January 1995

POST-HEARING QUESTIONS
CONCERNING THE JULY 10, 1997
HEARING ON DRAFT LEGISLATION ON
PHARMACEUTICAL PRICES, HOMELESS VETERANS' PROGRAMS,
AND ISSUES RELATED TO PERSIAN GULF WAR ILLNESS

QUESTIONS FROM THE HONORABLE LUIS GUTIERREZ
RANKING DEMOCRATIC MEMBER, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

TO JOHN OGDEN, CHIEF CONSULTANT, PHARMACY
BENEFITS MANAGEMENT STRATEGIC HEALTHCARE GROUP
DEPARTMENT OF VETERANS AFFAIRS

QUESTION 1: Mr. Ogden, Ms. Steinhardt has outlined some of the pharmaceutical manufacturers' potential responses to allowing state and local providers to make purchases off of the federal supply schedule. All of them are fairly unpromising for VA to negotiate as successfully as they have in the past. Do you agree that negotiations for the Federal Supply Schedule will be more difficult if new authority is provided state and local providers?

ANSWER: Yes, I agree with Ms. Steinhardt's metaphor where she compared opening the Federal Supply Schedules (FSS) for pharmaceuticals to pushing a balloon in one spot causing expansion in another. Specifically, opening Federal Supply Schedules for pharmaceuticals to state and local entities would not result in their mandated compliance to procure from such schedules, i.e. they could pick and choose their procurement activity. In addition, if a lack of prompt payment is perceived by manufacturers from these entities, then there is little doubt our FSS negotiations would be more difficult and not as successful as in the past. The end result of these and other actions would be a tendency toward increased prices due to lost revenue within the pharmaceutical industry.

QUESTION 2: In your opinion, will VA experience a price increase for pharmaceuticals (drugs) if state and local providers are allowed to purchase them from the Federal Supply Schedule? Will you summarize the findings of your February 1995 analysis of this potential impact?

ANSWER:

A. Yes.

B. Our 1995 analysis projected a $153 million increase in VA expenditures if FSS pharmaceutical schedules were opened to state and local entities. This figure was based on assumed actions by the pharmaceutical industry, i.e., non-covered drugs would be withdrawn from the FSS with a resultant price increase and all covered drugs with an FSS price below the mandated ceiling price would increase to the federal ceiling price. The calculation of the effect on VA was based on actual data from contract purchases through the VA prime vendor network from January 1, 1994, through June 30, 1994. Non-contract pharmaceuticals, IV solutions, manufacturer direct purchases and purchases through the VA Depot System were not included in the calculation. The $153 million estimate did not include the impact on the other federal agencies such as the Department of Defense or U.S. Public Health Service.

QUESTION 3: Will VA be able to sustain a potential $150 million increase which on VA analysis says could result due to allowing state and local purchasers access to the Federal Supply Schedule? What will it do to either improve its negotiating or find savings to accommodate a price increase?

ANSWER:

A. In the overall context of VA's medical care budget, we, in my opinion, could sustain a $150 million increase due to this action. **However, sustaining this annual $150 million or greater increase would occur at the expense of the number of patients VA treats. The Deputy Under Secretary for Health, Dr. Garthwaite, discussed the effect of this magnitude of increase on our ability to provide care for veterans in response to a question from the Chairman during the Hearing. He indicated the number of veterans we treat across the system would be adversely affected.**

B. To improve our negotiating effectiveness from a business perspective, my recommendation to the Secretary of Veterans Affairs and the Under Secretary for Health, if this action occurred, would be to try to negotiate contracts, separate and distinct from the FSS process, for pharmaceuticals utilized in the VA healthcare system. Through effective and efficient contracting and clinical actions taken in the last seven to ten years our ability to find savings in pharmaceutical procurements over and above those already accrued would be very difficult. Note, however, that this alternative approach would require cooperation and agreement from each pharmaceutical company from whom we procure, and because it would entail in excess of 22,000 drugs, it could take years to accomplish this.

QUESTION 4: In your opinion, should state and local purchasers be excluded from purchasing pharmaceuticals from the Federal Supply Schedule? Would you support legislation to this effect?

ANSWER:

A. Yes.

B. VA's consistent position since the passage of the cooperative purchasing legislation in 1994 is exclusion of the FSS pharmaceutical price schedules from the implementation of the Federal Acquisition Streamlining Act (FASA) legislation. If that is not possible, I personally would support legislation excluding state and local purchasers of pharmaceuticals from the Federal Supply Schedule.

QUESTION 5: Do you agree with the findings in the GAO's report on federal drug prices? (IF NO: What aspects, in particular, do you disagree with?)

ANSWER: In general, I agree with the findings of the GAO's report that "the effects of opening the Federal Supply Schedule for pharmaceuticals are uncertain." However, I thought Ms. Steinhardt's oral comments at the hearing were much more to the point in supporting VA's consistent posture on the effects of this action. In reviewing GAO's specific recommendations that "the effects of opening the federal supply schedule for pharmaceuticals on schedule prices ultimately depend on the outcomes of negotiations between VA and drug manufacturers," I think our past analyses, formal and informal communications with GSA on this subject, and testimony during the Hearing more than

adequately state and represent VA's concerns about the potential adverse effects of opening the pharmaceutical FSS to state and local entities. Further, the GAO report did not present the worst case scenario of possible effort(s) by the pharmaceutical industry to seek repeal of the drug pricing sections of P.L. 102-585. Such action, if achieved, would have a dramatic upward price impact on federal buyers.

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QUESTIONS FROM THE HONORABLE LUIS GUTIERREZ
RANKING DEMOCRATIC MEMBER, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

TO THOMAS GARTHWAITE, M.D.
DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS

QUESTION 1: Dr. Garthwaite, your testimony states that you have no objection to formally evaluating the effectiveness of organizations who receive grants and per diem rates to work with homeless veterans. Have you considered what measures VA will assess in meeting this mandate?

ANSWER: We are currently monitoring the organizations' projects created as a result of Homeless Providers Grant and Per Diem Program grant funds. At this time, 18 projects are completed and operating and, although most of the information collected up to this point has been baseline data, we are beginning to compile this data to determine the effectiveness of the services provided to homeless veterans. We are monitoring three aspects of program implementation/provision of services: 1) program capacity/cost effectiveness; 2) clinician related outcomes; and 3) veteran satisfaction.

Additionally, as organizations complete the facilities constructed or renovated with grant funds and apply for recognition for per diem payments, inspections of the projects are initiated by designated VA medical center personnel. These inspections provide VA with information to assess program performance and to determine feasibility of program design while ensuring maintenance of standards that comply with rules and regulations. Once projects are in operation these inspections are conducted on a yearly basis.

QUESTION 2: What is the strategic direction VA is looking at for homeless programs? What are the goals you will seek?

ANSWER: The mission of VA's Homeless Veterans Treatment and Assistance Programs is to address the causes and effects of homelessness among veterans. This is accomplished by providing direct services such as outreach, case management, residential treatment, therapeutic work opportunities, and assistance with permanent housing for homeless veterans and those veterans at risk for homelessness, and by coordinating the provision of care with other Federal, state, and local agencies as well as community non-profit organizations and private entities.

The following are objectives of VA's homeless programs:

- Continue to facilitate and seek community collaborations;
- Continue to facilitate linkages with other Federal agencies;

- Continue community outreach to those under-served veterans;
- Continue to provide ongoing case management to foster veterans self-determination and assist in their ability to function at their optimal level;
- Strengthen capacity and effectiveness to provide a hospital without walls;
- Increase programs' ability to provide comprehensive and extensive treatment within this format;
- Export models of service delivery that have shown demonstrated effectiveness to areas of the country where homeless veteran initiatives have not yet been developed;
- Develop new initiatives for in-reach to inpatient homeless populations;
- Foster a continuum of homeless care in each VISN through a coordinated network approach; and
- Pending legislation, continue the process to nationally assess and meet the needs of the homeless veterans population through project CHALENG.

QUESTION 3: Will VA expand both the breadth and depth of its non-institutional options for nursing home care if the authority for this program is made permanent? What are your goals for this program?

ANSWER: VA has used the authority for the pilot program, Non-Institutional Alternatives to Nursing Home Care, to provide homemaker/home health aide services to patients who meet nursing home admission criteria, but reside at home. A 1995 Congressionally-mandated study of the pilot program found the services to be well received by patients, families and VA staff.

VA has approved the use of funds for other community-based long-term care services on a case-by-case basis. Additional services will continue to be added, when these envisioned services offer some potential that nursing home placements can be delayed or entirely diverted, and that the envisioned services positively affect the quality of care and quality of life of patients. These criteria, reduction in nursing home days and improved quality of care and life, also reflect VA' goals for these services.

VA expenditures for homemaker/home health aide services increased by 25.1 percent in FY 1996, to a total of $22.3 million. VA anticipates continued expansion of these services.

QUESTION 4: I am pleased to hear that you are supportive of the proposal to compete grants for innovative Persian Gulf treatment programs. I am also pleased that Congress may be able to support you in offering this care to a broad base of veterans with symptoms from their deployment. What are the types of activities that you believe VA has been reluctant to explore that this legislation would allow? Do you believe the programs this

legislation allows will lead to increased levels of Persian Gulf veterans' satisfaction with healthcare services?

ANSWER: In response to the need to explore treatment options, VA has formed a Planning Group to explore the development of treatment outcome trials on the diagnostic categories of chronic fatigue syndrome, fibromyalgia, and other symptom-based disorders that bear a resemblance to these. The Planning Group will meet in early September, 1997 to begin working on the problem. Parallel with this, VA is preparing a Program Announcement to be issued this summer to VA investigators. The Program Announcement invites VA investigators to submit Planning Requests to be considered for development into one or more multi-center treatment trials using VA's Cooperative Studies Program as the platform for the conduct of this research. Because multi-center trials are very complex, the development of an operational trial will take between nine and eighteen months, provided the final product passes VA Cooperative Studies peer review processes. VA will provide a progress update within 120 days of this response.

If more effective treatments can be developed, patient satisfaction is very likely to improve. Veterans want to be well and we need to work diligently to improve their sense of health and well-being.

QUESTION 5: A number of advocates for the homeless have expressed concern that the new enrollment process for VA healthcare could jeopardize access to care for many homeless and mentally ill veterans. These veterans generally do not have a stable address and cannot be easily notified by mail during open enrollment season. Many of these veterans have mental impairments that make it difficult for them to understand a complex enrollment process or to even understand the need to enroll.

How does the VA plan to accommodate these veterans within the context of a new enrollment process for VA healthcare?

Answer: Dr. Kizer has concurred with the recommendation of the Eligibility Reform Steering Committee to consider homeless veterans who suffer from functional impairment due to substance abuse or mental illness as part of one of the disabled veterans specialized needs groups. Dr. Kizer has also concurred with the following policy recommendations for implementing enrollment nationwide: rolling enrollment which will allow for enrollment throughout the year; automatic enrollment of veterans who received care during the previous 12 months; enrollment of veterans when they present for care; and a one year test of enrollment on a national basis. For those homeless veterans who are not currently using the VA healthcare system, the rolling enrollment process will allow them to report to any VA facility at any time and apply for care, and they will be enrolled if eligible. As with any new system, exceptions will have to be made for those veterans who were not aware of the enrollment process for any reason. VA staff are currently working on materials and methods to communicate to veterans and medical center staff the changes brought about by the law. VHA believes that the Veterans Service Organizations can play a critical role at the national and local levels in our education and communication efforts. Although the policy and process decisions are still being developed, VHA is committed to adopting a straightforward process and making enrollment as easy and thorough as possible for the veterans and VA.

QUESTION 6: Women veterans who are homeless and suffer with chronic mental illness present with somewhat different treatment issues than their male counterparts. These issues range from assurance of adequate privacy and safety during episodes of inpatient care to ensuring access to residential treatment, transitional housing, and other supportive interventions designed for groups of veterans.

What steps has VA taken to assure that treatment issues specific to women veterans are integrated within the scope of programs and services designed for homeless and/or seriously mentally ill veterans?

ANSWER: VA Homeless Treatment and Assistance Programs have been actively seeking to address the problems of homelessness among women veterans. During FY 1995, 2.3 percent of veterans contacted (588) who were seen in the Health Care for Homeless Veterans (HCHV) Programs were women. This proportion is within the expected range, given the number of women among the veteran population, and the number of women among the homeless. However, in some locations across the country HCHV programs appear to be seeing more homeless women veterans. In 1995, for example 6.6 percent of homeless veterans treated at VA Medical Center West Haven, CT, HCHV program were homeless women veterans. We are beginning to see an increase in the number of homeless women veterans who are being treated in the Domiciliary Care for Homeless Veterans (DCHV) Programs. In 1989, 2.1 percent of veterans treated in this program were homeless women veterans. In 1995, that percentage had increased to 3.7 percent.

During the last two years, VA program officials have made a concerted effort to increase the awareness of VA clinicians and non-profit groups concerning homeless women veterans. Some of these efforts have included:

- Dedicated tents and activities for women veterans at "Stand Downs" for homeless veterans.
- Collaborations with VA Women Centers and Homeless Programs.
- VA Homeless Programs' collaborations with local non-profit community providers.
- VA partnerships with local agencies to support community and non-profit organizations' initiatives for homeless women veterans (e.g., Vietnam Veterans of San Diego has separate housing and treatment for women veterans).

Additionally, although still a new program, initial baseline data collected from VA's Homeless Providers Grant and Per Diem Program shows 4.8 percent of the population utilizing the program were women veterans. During the past three rounds of grant awards, many proposals submitted for funding targeted women veterans as their specific service population. We predict most projects, once completed, will have at least partial capacity to serve women veterans. Moreover, program legislation allows 25 percent of project beds to be occupied by non-veterans, encouraging providers to accommodate the spouses and/or children of homeless veterans.

VA realizes the uniqueness of this special population and will continue working with other agencies to assure that the needs of women veterans are addressed.

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QUESTIONS FROM THE HONORABLE LUIS GUTIERREZ
RANKING DEMOCRATIC MEMBER, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

TO ROBERT ROSENHECK, M.D.
DIRECTOR, NORTHEAST PROGRAM, EVALUATION CENTER
DEPARTMENT OF VETERANS AFFAIRS

QUESTION 1: Dr. Rosenheck, there is a provision in the legislation you were asked to address which would require drug-testing and expulsion of homeless veterans using the Compensated Work Therapy/Transitional Residencies Program. Your statement indicates that you may believe that submitting to urinanalysis gives homeless veterans a sense of responsibility? While it would be nice to think that we could get a 100% cure for these veterans, it is my understanding that a realistic goal of VA's substance abuse programs is to lessen addiction and the negative behaviors that drug use may elicit. First of all is this provision enforceable? Is this provision somewhat punitive?

ANSWER: Our studies, as you note, indicate the urine testing is associated with clinical improvement. On the basis of this finding we agree with a clinical recommendation that residential programs for veterans with substance abuse disorders should routinely conduct urine tests. The Department supports the provision providing for expulsion of participants found to be using illegal drugs during VA treatment.

QUESTION 2: Dr. Rosenheck, I first want to commend you on the diverse range of services VA offers homeless veterans. Do you believe that there are some programs that are more effective than others? Should we offer more of this type of program at the expense of others?

ANSWER: We have compared contract residential treatment programs and VA domiciliary programs and found them to be equally effective in treating mental illnesses. We have also compared residential treatment with pure case management and found residential treatment to be more effective, but quite a bit more expensive. We have also compared standard case management with the joint HUD-VA supported housing program and found the latter to have superior housing outcomes, although it also requires considerable investment in both VA clinical resources and HUD Section 8 vouchers. The conclusion from these studies is that no program has both more effective and less costly than the others. We, therefore, have chosen to maintain a balanced portfolio of programs of varying intensities, emphasizing the less expensive programs so as to treat larger numbers of homeless mentally ill veterans.

QUESTION 3: How have your efforts to track spending for the chronically mentally ill been helped or hampered by the decentralization of funding and management in the VA system? Are you still able to do your job as effectively?

ANSWER: There have been some changes in VA data systems as the management of VA clinical programs has been decentralized to the VISNs. However our ability to monitor spending for special emphasis programs has been maintained because Dr. Kizer has made it emphatically clear that performance monitoring at the national level, including monitoring of efficiency and resource consumption, is a major priority.

QUESTION 4: Dr. Rosenheck, your statistics for the veterans who complete homelessness treatment programs are impressive. How many veterans start receiving care in VA's homeless programs and do not complete it? Do you have any idea what happens to them?

ANSWER: About half of veterans who begin residential treatment or domiciliary care successfully complete the program. Those who do not successfully complete the program, however, generally do continue to receive services from VA. An outcome study of graduates of VA homeless programs showed that those who did not complete the program had poorer outcomes than those who did, but that about 40 percent had obtained housing and were in treatment 6 months after being discharged from the program.

QUESTION 5: You mention that homeless veterans using VA healthcare are intensive healthcare users; what are their most prevalent health problems?

ANSWER: Considering all health problems, the most prevalent primary diagnoses (i.e., the principal reason for admission) among homeless inpatients are alcohol abuse (29 percent); drug abuse (16 percent); schizophrenia (15 percent); other psychotic disorders (10.0 percent); PTSD (5.8 percent); cardiac disease (1.6 percent); cancer (1.6 percent); respiratory disease (1.4 percent); and cerebrovascular disease (1 percent). Of course many of these veterans have multiple illnesses. About half of those with serious mental illness also have significant chronic medical illnesses.

QUESTION 6: Some of the contract providers have submitted testimony that indicates that they think VA ought to be using them to provide most of the care VA offers to homeless veterans. In your opinion, are the majority of the providers who receive grant per diem payments qualified to respond to the chronic healthcare problems, such as schizophrenia, post-traumatic stress disorder, substance abuse, as well as medical problems manifested by these veterans?

ANSWER: Among the homeless, schizophrenia, PTSD, substance abuse and medical illnesses all require careful medical assessment and treatment, best provided by medically qualified professionals. It is also clear that homeless veterans have many other, non-medical needs, some of which can be well addressed by community-based organizations. For this reason we view the partnership that has developed between VA and community-based organizations across the country during the past decade as, by far, the most effective and efficient approach to helping homeless veterans with serious illnesses. It would be counterproductive to return to the contentious, either-or, relationship that we have worked diligently to put behind us.

QUESTION 7: Dr. Rosenheck, your testimony states that 31% of all VA's mental health inpatients are homeless. I find that

staggering. VA is now eliminating many of its inpatient beds - substance abuse, post-traumatic stress disorder and psychiatric care are some of the types of beds being extensively targeted. First, is there evidence that those resources are being retrenched into community and outpatient programs for the same purposes? Next, can veterans get effective care for these serious problems without a stable or supportive living environment?

ANSWER: From FY 1995 to FY 1996 inpatient mental health expenditures declined by about $79 million, while outpatient care increased by about $60 million. While there was thus an important shift of funds from inpatient care to outpatient care, only limited funds were channeled to the type of specialized programs that serve homeless mentally ill veterans. A special initiative, however, the Community Homeless Health Care Triage Program, has recently been initiated to stimulate development and coordination of programs, based on established VA models, in each VISN. As to your second question, it is true that homeless veterans often need temporary shelter and residential support. However, this care does not need to take place in hospital beds. Various forms of supportive housing have been demonstrated to be effective, as have intensive case management approaches. The central issue is to develop specialized alternatives that are adequately funded to meet the residential care needs of homeless veterans.

July 10, 1997 HEARING
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON VETERANS AFFAIRS

Reply to questions from The Honorable Luis Gutierrez
Ranking Democratic Member

From Linda Boone, Executive Director
National Coalition for Homeless Veterans

1. Do your member organizations have difficulty in securing funding for the provision of services homeless veterans need?

Yes, our member organizations do experience inordinate difficulty in accessing resources from the Job Training Partnership Act (JTPA), other funding sources from the United States Department of Labor, as well as extreme difficulty in securing funding from sources emanating from the Department of Housing & Urban Development, Department of Health & Human Services, or other Federal resources.

The local entities that control funds designed to assist homeless persons often seem take an attitude that "*Veterans are a Federal responsibility*". The concomitant elements of this attitude are often to indicate that if the Congress had intended these programs to assist veterans, then veterans would have been explicitly written into each part of each program.

Our hard experience indicates that **unless** the Congress explicitly "***writes in***" veterans in every provision of programs such as JTPA, then veterans are all too often expressly "***read out***" of the program at the state and local level. The typical scenario is that it is suggested that our member organizations seek funding and/or assistance from the VA. However, contract funds from VA are all too limited.

Given the problems of veteran service providers in securing funds from other sources, and particularly in light of the shifts of delivery from *inpatient* care to *outpatient* care on as massive a scale as is now occurring, $28 Million per year is just not adequate in the face of the need for transitional housing and other supportive services, to include basic needs.

The **National Coalition *for* Homeless Veterans (NCHV)** and our member organizations are eager to "partner" with the VA to best meet the needs of homeless veterans. The problem is all too often that our member organizations do not have anywhere near sufficient resources to be able to "partner" with the VA. In light of the exponentially growing need for transitional and other supportive housing being created by the shift of VA from inpatient to outpatient care, the status quo is just not adequate. That is the reality that we were trying to interject into the hearing.

NCHV is grateful for the strides that VA has made in regard to contracting for ongoing delivery of services from true community based organizations (something virtually not done just a dozen years ago), but assisting 30,000 veterans a year with contract programs is only reaching less than 10% of the VA's own estimate of the number of veterans homeless at some point during the course of a year.

We would suggest that we can and must do better. VA can and must contract out more resources, and with the help of the Congress the other funding sources that should be providing a proportionate share of resources to veteran specific programs can be made to do a better job.

2. What has been the experience of your member organizations in securing funds from the Stewart B. McKinney Act funds devoted to the homeless?

Only 3% of the HUD funds allocated pursuant to the McKinney Act are directed into veteran specific programs, even though the accepted estimate of the percentage of veterans among homeless adults is at least 30%.

Of HHS funds allocated for homeless programs the Project to Assist Transition from Homelessness (PATH) and Access to Community Care and Effective Services and Supports (ACCESS) only a small percent of veterans have received services.

FEMA has traditionally only spent about 1% of their McKinney funding towards veterans assistance.

For these reasons, the **National Coalition *for* Homeless Veterans (NCHV)** strongly favors enactment of HR 1754, introduced by the Honorable Jack Metcalf. **NCHV** urges all of the Members of the Committee on Veterans' Affairs to join Mr. Metcalf as co-sponsors of this attempt to ensure that veterans are not literally "left out in the cold" when it comes to securing Federal resources to meet their *special needs.*

3. What would you recommend VA do to better support the development of the organizational capacity to deliver more and better quality services to veterans who are homeless?

NCHV favors extending the authority for the VA to contract for *Drug and Alcohol Treatment* until December 31, 2000. We would suggest that it may be time to make this program permanent when it comes up for renewal again.

NCHV would also suggest that the Committee take action to encourage the VA to extend the utilization of this authority more widely, and to focus on the "whole person" in treatment programs, in a manner that promotes re-establishment of pride and responsibility in veterans. In almost all cases this will involve assisting a veterans to obtain and sustain meaningful employment at a decent living wage.

Extension of the authority, adequate resource shifts, and VA willingness to contract where appropriate is all the more urgent in light of the diminishment of substance abuse and neuro-psychiatric programs in particular.

NCHV favors extending the authority for *Noninstitutional Alternatives to Nursing Home Care* for another three years. **NCHV** would further suggest that "clustering" of services and alternatives in small or relatively small facilities is what seems to work in the experience of most of our member organizations. While most of the media and official attention in regard to homelessness of veterans has focused on Vietnam veterans and those younger veterans who served since 1975, there is a significant problem for older veterans. Oftentimes these veterans are a "hidden problem", much as malnutrition and poverty among the elderly is "hidden" in the sense that it is not as readily visible on our streets as are the problems of younger veterans.

NCHV favors extension for *Housing* Assistance *for Homeless Veterans* for at least three more years, as proposed. This program has proven to be a valuable tool in assisting veterans to take the step back toward independence and autonomy.

NCHV favors extension of the authority for the *Demonstration Program of Compensated Work Therapy* for another three years. Many of our member organizations have utilized this program to great benefit for the veterans participants.

We would suggest, however, more emphasis be encouraged toward directing early transition into more meaningful work, assisting veterans to acquire truly marketable skills that can lead to a decent wage. The overall goal must be focused toward a veteran achieving full independence again. In many cases it may be fruitful to encourage more partnerships with both private for-profit as well as not-for-profit entities in order to successfully design and implement such programs that are sustainable. Perhaps the VA should concentrate on managing the course of therapy and treatment for the individual, and secure the services of outside expertise to better deal with the business aspects of the operation.

NCHV strongly favors extending Public Law 102-590; 38 U.S.C. 7721 until December 31, 1999. The improvement of both the quality services delivered by VA to homeless veterans and the number of veterans reached as a result of this act are to be commended.

The effort to bring a greater degree on equity into the new resource allocation model adopted by VA is commendable, and NCHV supports this measure. Our concern in particularly centered on states in the Northeast and "Rust Belt" states. While it is true that the shifts in the veterans population reflects the move toward the "Sun Belt" of the general population, a more careful look at those who remain behind is in order here. Those with the most resources are more typically those who are moving south.

Those veterans who remain in Illinois, New York, and other areas of the north central and northeast sections of our country tend to be older, poorer, and more prone to illness in comparison to their more affluent comrades who had the resources to migrate to a warmer climate. The chronic and acute conditions that beset this remaining veterans' population in these northern states make treating them more expensive. No one said to any of those now aging veterans when they were a young inductee or enlistee in Illinois or New York, "Sorry. You cannot pledge your life in defense of the United States Constitution or fight in this war because you come from a "high cost state". Yet many of these veterans will receive less care or perhaps even no medical care if they still reside in these northern states *if* the new allocation model is not modified.

Of particular concern to the **National Coalition *for* Homeless Veterans** is the approaching deadline for "registration." Homeless veterans are quite often peripatetic by definition. Many veterans who are now homeless and who have never or rarely used a VA medical facility could well be homeless and in vital need of such services by this time next year. However, if they have not "registered" then they may well be denied care.

It is useful to reiterate that "homeless veterans" are not a discrete group of veterans. Rather, homeless veterans are veterans whose problems, which are often service related, become so acute that they find themselves homeless for a period of time. As noted, while VA estimates there are 275,000 homeless on any give night, double that number of veterans will be homeless at some point during the year. Virtually no person foresees and plans for the disaster of becoming homeless.

NCHV urges the Committee to take steps to "Hold Harmless" veterans who are not registered, and allow them to receive medical services for which they otherwise be entitled. However it is done, NCHV believes that this is a concern that will be a crisis by the Autumn and Winter months if not addressed soon.

An additional concern of **NCHV** is that change is occurring a geometrically accelerating pace within the Veterans Health Administration, and that not all elements of the veterans' community is even being kept informed much less consulted. We ask your assistance to ensure that all of the twenty two *Veterans Integrated Service Networks (VISNs)* include

homeless veterans services providers and other veterans' community based organizations in the membership of the "Management Advisory Committees" (MACS) and any other stakeholders body or gathering at the VISN or VA Medical Center level.

NCHV also respectfully requests the Committee take all due oversight steps necessary to ensure that the MACS and other means of consultation with stakeholders is truly substantive and a means for real "two way" communication in each *VISN*, and not merely for purposes of representing to VA Central office that a stakeholders meeting was held.

As noted or implied in numerous allusions, a principal problem for homeless veterans is finding a safe place to live while undergoing therapy and struggling to sustain meaningful employment. There is just not now enough (nor is there likely to be) enough grant funds to build such housing. Therefore, **NCHV** would suggest leveraging private funds and partnering with the private sector in order to create more successful therapeutic housing capacity. We would also suggest the Committee consider adding a provision that would allow up to $100 Million in guaranteed loans to construct *Veterans Transitional Housing.*

While such a guarantee program may have to entail a new program at the Department of Housing and Urban Development to implement such a change in Title 38, such capacity must be created by means of some mechanism that leverages private funding, in our view. We would suggest that simple but strict guidelines be included to ensure the successful operation of such housing, as well as the financial viability of entities receiving benefit of one of a limited number of such guarantees.

Lastly, **NCHV** recommends that the VA be even more strongly encouraged to contract out a greater proportion of their resources to true community based organizations with a proven track record of meeting the *special needs* of veterans.

4. Your testimony says that funding for inpatient mental services should be driven into responding to "unmet need" rather than reassigned to other types of care. What programs would best respond to unmet needs.

The Veterans Health Administration is dramatically curtailing inpatient mental health services in VA Medical Centers all across the Nation. The assurances given to **NCHV** and to our member organizations has been that the resources thus diverted from delivery of treatment on an inpatient basis for substance abuse, post traumatic stress disorder and other war related neuro-psychiatric wound, and for general mental health services will be redirected toward outpatient delivery of the same types of services, but in a more effective and efficient modality of treatment. Anecdotal reports would suggest that most of the funds saved from diminishing inpatient mental health services are *NOT being reprogrammed into outpatient delivery of the same types of services.* **NCHV** has asked this question directly of Dr. Kizer, and not received a direct reply.

Reducing the mental health services without creating the community network to effectively treat these veterans is all too reminiscent of the dumping" of patients onto the street from public mental hospitals using the "Madison Model" as justificatory theory.

While **NCHV** is not charging VA with "dumping" we are very concerned that the reductions in "inpatient capacity" is seemingly not being matched by an investment of those same resources "saved" in developing outpatient services at the same facility, or in carefully developing and nurturing the organizational capacity of true community based organizations to assist the veterans not now being treated on an inpatient basis.

Assurances that outpatient treatment for substance abuse or PTSD is statistically more effective rings very hollow in the ears of a veteran who is homeless and has no safe (much less supportive) place to live while receiving outpatient treatment. It reminds Vietnam veterans all too much of MACV assuring the soldiers in the field that we were winning the war.

There is no one program that would address these needs, but rather a more concerted effort to ensure that each *Veterans Integrated Service Network (*VISN) and each VA Medical Center was maintaining at least the same proportion of funds directed into mental health services as in previous Fiscal Years.

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